26. QUICK REFERENCE

A. Quick Reference Guide

IEHP Quick Reference Guide

Main Number:	(909) 890-2000
Main Fax Number:	(909) 890-2002
Provider Relations Support Team:	(909) 890-2054 or (866) 223-4347
Provider Relations Fax:	(909) 890-2968
Eligibility:	
IEHP's Secure Provider Portal:	www.iehp.org
Member Services:	
IEHP Member Services Support:	(877) 273-IEHP (4347)
Enrollment Assistance:	(866) 294-IEHP (4347)
TTY Member Services:	(800) 718-IEHP (4347) or (909) 890-0731
TTY Enrollment Assistance:	(800) 720-IEHP (4347) or (909) 890-1623
After Hours Nurse Advice Line:	(888) 244-IEHP (4347)
Hours of Operation:	Monday – Friday 8:00 a.m. - 5:00 p.m.
IEHP's UM Staff and Physicians: (Provider inquiries regarding authorization request, status and clinical decision and process)	Monday – Friday 8:00 a.m. - 5:00 p.m.
IEHP website:	www.iehp.org
Provider Relations Team Email:	ProviderServices@iehp.org

Closed For:	New Year's Day	Veteran's Day
	Martin Luther King, Jr. Day	Thanksgiving Day
	Presidents' Day	Day After Thanksgiving
	Memorial Day	Christmas Eve
	Juneteenth	Christmas Day
	Independence Day	New Years' Eve*
	Labor Day	

**IEHP will designate an "alternative holiday" each year.*

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
ABC	Alternative Birth Center; A health facility that is not a hospital and is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan.
ABMS	American Board of Medical Specialties; delineates board certification standards; used for credentialing purposes.
ABPS	American Board of Podiatric Specialties; issues board certification to qualifying practitioners; used for credentialing purposes.
Abuse	Abuse applies to practices that are inconsistent with sound fiscal, business, medical or recipient practices and result in unnecessary cost to a health care program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
ACIP	Advisory Committee on Immunization Practice; national entity that issues guidelines on immunizations; DHCS contract mandates that these guidelines be followed by IEHP network PCPs.
ADL	Activities of Daily Living; These are everyday routines generally involving functional mobility and personal care such as bathing, dressing, toileting, and meal preparation.
Admitting Physician	The doctor responsible for admitting a patient to a Hospital or other inpatient health facility.
Advance Directive	A written legal document that details treatment preferences for any health care decisions when a Member is unable to speak for themselves. Examples of advance directives include (but not limited to): a living will, a Durable Power of Attorney form, a health care proxy, a Physician Orders of Life Sustaining Treatment (POLST), Five Wishes and surrogate decision maker. This document must comply with State and Federal law.
Adverse Event	An injury that occurs while a Member is receiving healthcare service from a Practitioner.
AEVS	Automated Eligibility and Verification System; DHCS phone system to verify eligibility for Medi-Cal recipients.
Agency	The relevant state licensing agency having regulatory jurisdiction over the licentiates.
Agreement	Same as contract; signed document between IEHP and Providers outlining responsibilities of both parties, may be capitated or per diem.
AMA	American Medical Association; Largest association of Physicians, including MDs, DOs, and Medical Students in the United States.
AOA	American Osteopathic Association; an organization that licenses osteopathic physicians; it also accredits hospitals; used for credentialing and oversight purposes.

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
AOR	Provider Acknowledgment of Receipt (AOR); Provider and all appropriate staff attest that they have received and/or been trained on the information contained in the Policy and Procedure Manual, Electronic Data Interchange (EDI) Manual (if applicable), IEHP Code of Business Conduct and Ethics, Guidelines for Care Management Training, General Compliance Training and Culture and Linguistic (C&L) Training.
AOR	Appointment of Representative; This is the process by which an individual is formally appointed by the Member as their representative to make any request, present or elicit evidence, obtain appeals information, and receive any notice in connection with the Member's claim, appeal, grievance or request.
APP	Advanced Practice Practitioners are identified as Physician Assistants, Nurse Practitioners and Nurse Midwives.
Appeal	The review of an adverse initial determination to mean any of the following actions taken by the health plan or the IPA: denial or limited authorization of a requested service; reduction, suspension, or termination of a previously authorized service; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner; failure to act within the required timeframes for standard and expedited resolution of Appeals; denial of the Member's request to obtain services outside of the network; and denial of a Member's request to dispute financial liability.
Appointment Waiting Time	Means the time from the initial request for health care services by an enrollee or the enrollee's treating Provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting Providers.
ASC	Ambulatory Surgical Centers; also known as free-standing surgi-centers or outpatient surgery centers; a facility not under the license of a hospital; devoted primarily to the provision of surgical treatment to patients not requiring hospitalization; these facilities generally do not provide accommodation of treatment of patients for periods of 24 hours or longer.
Automated Verification	Requires there be a mechanism to identify the name of the entity verifying the information, the date of the verification, the source, and the report date, if applicable.
BAE	Best Available Evidence; Documentation used by IEHP to support a favorable change to a low-income subsidy (LIS) eligible Member's LIS status.
Bed Day	Same as Hospital Day; any period up to 24 hours, commencing at 12:00AM during which a Member receives inpatient hospital services.
Behavioral Health	Includes all mental health (psychiatric, psychological and behavioral disorders) and substance abuse disorders.

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
Benefit Year	The benefit year for IEHP DualChoice Members is January 1st through December 31st annually.
Bi-annual	As used by IEHP; means twice yearly; synonymous with semi-annual.
BIC Card	Benefit Identification Card; issued to Medi-Cal recipients by DHCS; used to identify beneficiaries as Medi-Cal Members; does not guarantee eligibility.
CAHPS	Consumer Assessments of Healthcare Providers and Systems
CAP	Corrective Action Plan; written plan by a Provider or Delegate to remedy deficiencies.
Capitation	Monthly payment to Providers for pre-defined services; usually associated with HMOs and is paid regardless of services actually rendered; IEHP's capitation is a flat rate per member per month, based on the Aid code of the Member.
Care Coordination	Services which are included in Case Management, Complex Case Management, Comprehensive Medical Case Management Services, Person Centered Planning and Discharge Planning, and are included as part of a functioning Medical Home.
Case Management	A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Provider (PCP) or by a PCP-supervised Physician Assistant (PA), Nurse Practitioner (NP), or Certified Nurse Midwife, as the Medical Home, Coordination of carved out and linked services are considered basic case management services.
CBAS	Community Based Adult Services; a DHCS licensed community-based day care program providing a variety of health, therapeutic and social services to those as risk of being placed in a nursing home. This program replaced the ADHC benefit as of October 1, 2012.
Category 1 continuing medical education	Physicians, continuing medical education as qualifying for category 1 credit by the Medical Board of California. Nurse Practitioners (NPs), continuing medical education contact hours recognized by the California Board of Registered Nursing; and Physician Assistants (PAs), continuing medical education units approved by the American Association of Physician Assistants.
CBO	Community Based Organization; an entity providing resources and information on varis programs, e.g., Catholic Services.

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
CD	Coverage Determination; Any decision made by the health plan regarding: receipt of or payment for a prescription drug that a Member believes may be covered; a tiering or formulary exception request; the amount that the health plan requires a Member to pay for a Part D prescription drug; a limit on the quantity or dose of a requested drug; a requirement that a Member try another drug before the health plan pays for the requested drug; or a decision whether a Member has or has not satisfied prior authorization or other utilization management requirement.
CDS	Controlled Dangerous Substance; similar to DEA certification; an authorization issued to physicians writing prescriptions for controlled substances; used for credentialing purposes.
Chaperone	A member of the Provider's medical staff whose job is to enhance the patient's and Provider's comfort, safety, privacy, security and dignity during sensitive exams or procedures.
CHDP Program	Child Health and Disability Prevention Program; State program which issues guidelines on pediatric preventive services; IEHP uses guidelines for its Well Child Program per State requirements.
CIN	Client Index Number; a nine-digit alphanumeric number assigned to Medi-Cal Members by DHCS for Member identification.
CM	See Case Management
CMS	Centers for Medicare & Medicaid Services**;** federal regulatory body overseeing Medicare and Medicaid programs, of which California's Medi-Cal program is part; one of the regulatory bodies overseeing IEHP's operations.
CMS-1500 Claim Form	A federally approved claim form that meets the Centers for Medicare & Medicaid Services health insurance information collection requirements.
CMS Preclusions List	List of prescribers and individuals or entities who fall within any of the following categories: (1) Are currently revoked from Medicare, are under an active re-enrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program.
Clean Claim	A claim that can be processed without obtaining additional information from the provider of services or from a third party.
COB	Coordination of Benefits; a process followed when a Member has multiple coverages whereby the total cost of care for the Member either paid or reimbursed does not exceed 100%.
Cold-Call Marketing	Any unsolicited personal contact by the Contractor with a potential Member for the purpose of marketing (as identified within the definition of Marketing).

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
Compliance Committee	Compliance Committee; IEHP's administrative committee that oversees all activities of its Fraud, Waste and Abuse Program.
Contractor	Includes all contracted Providers and suppliers, First Tier Entities, Downstream Entities and any other entities involved in the delivery of payment for or monitoring of benefits.
Covered Services	Vision care services and materials that are described as benefits in the Member's Handbook and EOC.
CPO	Care Plan Options; Optional services that are not covered benefits but are available to IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) Members. These are provided at the health plan's discretion and are the financial responsibility of the health plan.
CPSP	Comprehensive Perinatal Services Program; a Medi-Cal program that provides a model of enhanced obstetric services for eligible low-income, pregnant and postpartum women.
CPT	Physician's Current Procedural Terminology (CPT); a listing of descriptive terms and identifying codes compiled and maintained by the American Medical Association and used to report medical services and procedures.
Credentialing	The process of ensuring Providers meet minimum standards including, but not limited to, clear and current licensing, board certification, malpractice coverage, adverse history including malpractice and disciplinary actions and equipment/instrumentation.
Credentialing Subcommittee	One of seven committees established by IEHP that reviews and approves practitioner's qualifications and credentials to participate in IEHP's network. It is a subcommittee of the QM Committee.
CSR	Certified Site Reviewer; A Physician or Registered Nurse trained and certified to conduct DHCS required Facility Site Review (FSR) and Medical Record Review (MRR) Surveys at Primary Care Provider (PCP) sites. Certified Site Reviewers can be designated as DHCS Certified Master Trainer (DHCS-CMT), DHCS Designated Plan Trainer (DHCS-DPT), or DHCS Certified Site Reviewer (DHCS-CSR).
CVO	Credentialing Verification Organization; an entity that performs pre-determined credentialing processes, such as primary source verifications.
Days	Unless otherwise stated, days always means calendar days; usually shown in lower case.
DDS	Department of Developmental Services; administers and oversees various State waiver programs which provide in-home and community-based care. Such programs are provided in lieu of institutionalization to Members with developmental disabilities, the aged, or those Members who are physically disabled or have AIDS.

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
DEA	Drug Enforcement Agency; federal agency that oversees the distribution and use of controlled substances; issues certificates to prescribing physicians allowing dispensing of controlled substances; used for credentialing purposes.
Death Master File (DMF)	Contains information about persons who had Social Security numbers and whose deaths were reported to the Social Security Administration from 1962 to the present; or persons who died before 1962, but whose Social Security accounts were still active in 1962.
Delegate	Delegate- A medical group, health plan, independent physician association, individual or entity contracted with IEHP to provide administrative services or health care services for a Medicare eligible IEHP Member.
DENC	Detailed Explanation of Non-Coverage
Denial or termination of staff privileges, membership, or employment	Includes failure or refusal to renew a contract or to renew, extend or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.
DHCS	Department of Health Care Services formerly DHS; State agency responsible for oversight of the Two-Plan Model Managed Care Program and IEHP's operations.
DHHS	United States Department of Health and Human Services protects the health of all Americans and fulfill that mission by providing for effective health and human services and fostering advances in medicine, public health, and social services. DHHS or HHS provides guidance and information related to regulations concerning HIPAA.
Digital signature	Type of electronic signature that encrypts documents with digital codes that particularly difficult to duplicate. It includes a certificate of authority, such as a Windows certificate, to ensure the validity of the signatory (the signature's author and owner).
Direct Observation Therapy	A course of treatment, or preventive treatment, for Tuberculosis in which the prescribed course of medication is administered to the person or taken by the person under direct observation by a trained healthcare worker.
Discharge Planning	Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
Disease Management	IEHP's Disease Management program, which is based on evidence-based clinical practice guidelines, is designed to identify Members with specific chronic diseases relevant to IEHP's membership and facilitate access to providers, health education activities, and other specific services to improve Member health outcomes.
DMHC	Department of Managed Health Care; effective 7/1/00, formerly the Department of Corporations (DOC); one of the State regulatory bodies which oversees IEHP operations; regulates Knox-Keene Health Care Service Plans, which allows IEHP to operate as an HMO.
DMR	Direct Member Reimbursement
DOA	Delegation Oversight Audit; An onsite review of a Delegates performance of delegated plan responsibilities.
Downstream Entity	Any party that enters into an acceptable written agreement below the level of the arrangement between an organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
DPSS	Department of Public Social Services; State agency responsible for the administration of health and welfare benefits, including eligibility for Medi-Cal.
ECRS	Expense and Cost Recovery System
ED	Emergency Department.
EFT	Electronic Funds Transfer; the mechanism by which capitation payments are made electronically to Providers by IEHP.
EIOD	Expedited Initial Organization Determination
Electronic signature	Symbols or other data in digital form attached to an electronically transmitted document as verification of the sender's intent to sign the document.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine could reasonable expect the absence of immediate medical attention to result in: (1) Placing the health of the individual (or in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; (2) Serious impairment to bodily function; or (3) Serious dysfunction of any bodily organ or part.
Encounter	Each visit a Member makes to a practitioner or Provider.
Encounter Data	Mandatory encounter data reported to IEHP by its Providers; includes detailed information on services provided to each Member in each month.
EOC	Evidence of Coverage; The agreement between IEHP and the Member which describes Covered Services and` which sets forth the terms and conditions of coverage and enrollment with IEHP.

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
Exception Request	A request to obtain a drug that is not included in the IEHP formulary, or to request to have a utilization management requirement waived (e.g., step therapy, prior authorization, quantity limit) for a formulary drug
Exempt Grievance	A type of grievance received by telephone, which are not coverage disputes or disputed health services involving medical necessity, experimental and/or investigational treatments or related to quality of care, and that are resolved by the close of the next business day. This is otherwise known as an "orally resolved" grievance.
834	A monthly and daily electronic transmission from DHCS, which contains eligibility and demographic data on IEHP Medi-Cal Members.
Family Planning Services	Services provided to individuals of child-bearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents.
Faxed signature	The "copy" or "duplication" of your signature (no matter the method, system or medium you choose) is referred to as a facsimile signature.
FDA	Food and Drug Administration
FDR	First tier, downstream, and related entities
FEMA	Federal Emergency Management Agency
FFS	Fee-For-Service; a method of claims payment whereby the amount of reimbursement is determined by the type of service rendered by the provider of service; the amount of reimbursement is based on a set fee schedule that varies according to the type of services rendered.
First Tier Entity	Any party that enters into a written arrangement with an organization or contract applicant to provide administrative or health care services for an eligible individual.
FTP	File Transfer Protocol; method used to obtain and transmit Member eligibility and encounter data from/to IEHP.
Formulary	A list of medications approved by the Plan.
FPC	Fraud Prevention Committee; IEHP's administrative committee that oversees all activities of its FPP.
FPP	Fraud Prevention Program; Developed to train IEHP staff and Providers to identify, deter, prevent and report suspected fraudulent activities.
Fraud	Fraud is intentional or knowing misrepresentation made by a person with the intent or knowledge that could result in some unauthorized benefit to him/herself or another person. It includes any portion that constitutes fraud under applicable Federal or State law.

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
Fraud, Waste and Abuse Program	Fraud, Waste and Abuse Program; Developed to train IEHP staff and Providers to identify, deter, prevent and report suspected fraudulent activities.
FSR	Facility Site Review; An assessment of a Primary Care Provider's (PCP) site, performed by a Certified Site Reviewer using site audit tools, prior to the Provider site participating in IEHP's Provider network and upon relocation.
Global Risk	Global risk contracting is often used to describe the situation where a health plan enters into a capitation agreement with only one health care provider to shift the entire risk for the provision of both institutional and professional health care services to a single entity. These arrangements include almost all health plan services with a few exceptions such as pharmacy and behavioral health. This type of contracting is limited to organizations that have secured a Knox-Keene license or a Knox-Keene license with waivers. At times, the IPA may split the capitation with a hospital entity, thereby the financial responsibility is split between the IPA and Hospital.
Grievance	An oral or written expression of dissatisfaction regarding IEHP staff, policies or processes, our contracted providers' staff, processes or actions, or any other aspect of health care delivery through IEHP, including quality of care concerns.
HEDIS	Healthcare Effectiveness Data and Information Set; a tool used by health plans to measure performance on important dimensions of care and service.
HCO	Health Care Options, a unit of DHCS; handles both enrollment and disenrollment of Medi-Cal recipients; sometimes used interchangeably with Maximus.
HHA	Home Health Agency; entities that provide a wide range of health and social services delivered at home to persons recovering from an illness or injury, or persons with disabilities or chronic illness.
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization; provides health care services to enrolled Members for a fixed sum of money, paid in advance for a specified period of time; usually associated with managed care.
Hospital Day	Same as bed day.
Hospitalist	A doctor who primarily takes care of patients when they are in the hospital. This doctor will oversee a Member's care when the Member is inpatient, keeping the Member's primary doctor informed about the Member's progress, and will return the Member to the care of your primary care doctor when the Member is discharged from the hospital

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
HRA	Health Risk Assessment (HRA); A survey tool that is based on regulatory standards, stakeholder and consumer's input that assesses the medical, cognitive, functional needs and psychosocial status of the Members.
ICD-10-CM	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Clinical Modification. IEHP is in the 10th Clinical Modification. This is the system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care in the United States.
ICAP	Immediate Corrective Action Plan. A Corrective Action Plan issued by the plan to a Provider or Delegate to remedy serious deficiencies. ICAPs require a response within 72 hours of issue date.
ICP	Individualized Care Plan; treatment and intervention program for pregnant Members developed by OB; required by IEHP.
ICT	Interdisciplinary Care Team; A team comprised of the Primary Care Provider (PCP) and Nurse Care Manager, and other Providers at the direction of the Member, that works with the Member to develop, implement and maintain their individualized care plan (ICP).
IDN	Integrated Denial Notice
IEHP Identification Card	Issued by IEHP to Members; identifies PCP and Hospital affiliations; used for identifying beneficiaries as IEHP Members; does not guarantee eligibility.
IEHP Vision Provider	An Optometrist, Ophthalmologist or Optician who has signed a contract to participate in IEHP's Vision Program.
IHA	Initial Health Assessment; Consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables the PCP to comprehensively assess the Member's current acute, chronic and preventive health needs.
IHEBA	Individual Health Education Behavioral Assessment; a tool used to assess Member's behavioral health awareness and educational needs as part of PCP's health assessment for Members.
IHSS	In-Home Supportive Services; a statewide mandated program that provides those who meet the eligibility criteria of being aged, blind or disabled persons who are unable to perform activities of daily living and cannot remain safely in their own homes without help.
IM	Important Message from Medicare
Implementation Date:	NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
IMR	Independent Medical Review; a process run by DMHC, which provides an avenue for Members to request that doctors and other healthcare professionals outside IEHP, make an independent decision about the Member's healthcare; when a Member has been denied healthcare services on the basis that the services are not medically necessary and IEHP has concurred with the decision after the Member has completed the IEHP's grievance process. DMHC is the final arbiter regarding coverage decisions review through the IMR process.
Incentive Pool	IEHP program designed to help appropriately control inpatient length of stays; funded for Mandatory Medi-Cal Members only.
IPA	Independent Physician Association; network of licensed Providers practicing in their own offices, participating in managed care plan; type of Providers under IEHP's program.
The Joint Commission	The Joint Commission formerly Joint Commission for the Accreditation of Healthcare Organization (JCAHO); a not-for-profit organization that accredits hospitals, outpatient facilities and other institutions.
JOMs	Joint Operation Meetings; periodic meetings between IEHP and IPAs/Hospitals to address issues, delivery of care and general administration of plan.
JPA Governing Board	Joint Powers Agency Governing Board, also known as IEHP Governing Board; IEHP's oversight board consisting of appointed members from San Bernardino and Riverside Counties' Board of Supervisors and other appointed members that directs and approves all phases of IEHP operations.
LEIE	List of Excluded Individuals and Entities
LHD	Local Health Department (Riverside/San Bernardino Counties); provides specific preventive and public health services, including immunizations, which Members can access directly.
LI Plan	Local Initiative Plan; Public/Private partnership plan of California's Two-Plan Model Managed Care Program designed to provide a publicly and privately funded managed care health plan to Medi-Cal recipients; in San Bernardino/Riverside Counties this plan is IEHP.
Licentiate	A Physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage family therapist, clinical social worker, professional clinical counselor, dentist, licensed midwife, or physician's assistant. Licentiate also includes a person authorized to practice medicine pursuant to California Code, Business and Professions Code Section 2113 or 2168.
LIS	Low-income subsidy
LOA	Letter of Agreement
LOS	Length of Stay
LTAC	Long Term Acute Care

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
LTC	Long Term Care; a term used for day-in, day-out assistance required for a serious illness or disability that lasts a long time and in which a person is unable to care for him/herself; it frequently refers to custodial or nursing home care.
LTSS	Long-Term Services and Supports; in state Medicaid programs are a means to provide medical and non-medical services to seniors and people with disabilities in need of sustained assistance.
MA	Medicare Advantage
Mainstream Plan	Commercial line of California's Two-Plan Model Managed Care Program designed to provide a prepaid managed care health plan to Medi-Cal recipients; in San Bernardino/Riverside Counties, this plan is Molina.
Managed Care	A coordinated approach to providing quality health care at a lower cost; usually associated with HMOs.
Mandated Reporter	Healthcare providers who are acting in their professional capacities or within their scope of employment and provide medical services for a physical condition to a patient whom they know or reasonably suspect to have been abused. These individuals are responsible for directly informing the local law enforcement agency, within their respective county, of identified abuse.
Maternal Mental Health	Mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.
MBI	Medicare Beneficiary Identifier is a randomly generated Medicare number that will replace the SSN-based Health Insurance Claim Number (HICN) on Medicare cards for transactions like billing, eligibility status and claim status.
MBOC	Medical Board of California; the State agency that issues licenses to practitioners, including MDs and PAs.
MCO	Managed Care Organization; a term used in the industry, particularly by NCQA, for health plans that participate in managed care; also known as an HMO.
Medi-Cal	No-cost health care coverage for low-income adults, families with children, seniors, persons with disabilities, pregnant women, children in foster care and former foster youth up to age 26.
Medical disciplinary cause or reason	That aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to the patient's safety or to the delivery of patient care.
Medically Necessary	For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity," when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
Medicare Advantage Prescription Drug Plan HMO Special Needs Plan (SNP)	Health Plan coverage that includes a specific set of health benefits offered at a uniform premium and uniform level of cost sharing to all Medicare beneficiaries residing in the service area (or segment of the service area) of the MA plan. An MA plan that provides qualified prescription drug coverage under Part D of the Social Security Act. Beneficiaries are eligible to join if they are entitled to Medicare Part A and enrolled in Medicare Part B and are enrolled in Medi-Cal.
Member(s)	Any recipient enrolled in IEHP's plan.
MLTSS	Managed Long-Term Services and Supports; Services and supports provided by IEHP to Members who have functional limitations and/or chronic illnesses and which have the primary purpose of supporting the ability of the Member to live or work in the setting of their choice. MLTSS includes CBAS, LTC, IHSS, MSSP, and SNFs.
MMA	Medicare Modernization Act
MRR	Medical Record Review; Assessment of medical records that is performed at the time of Facility Site Review or if medical records are available.
MSE	Medical Screening Exam; to determine whether a patient has an emergency medical condition.
MSO	Management Services Organization; provides practice management services to IPAs and/or Hospitals.
MSR	Member Services Representative; IEHP employee responsible for handling Member calls.
MSSP	Multipurpose Senior Services Program; a State program that provides home and community-based services to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement.
MTM	Medication Therapy Management
NCD	National Coverage Determination
NCPDP	National Council for Prescription Drug Programs
NCQA	National Committee for Quality Assurance; a private, not-for-profit organization that assesses and reports on the quality of managed care plans. NCQA provides information that enables purchasers and consumers of managed health care to distinguish among plans based on quality, thereby allowing them to make more informed health care purchasing decisions.
NOMNC	Notice of Medicare Non-Coverage
Non-Emergency Medical Transportation	Transportation to one's IEHP or Delegate-approved medical appointment and/or Medi-Cal covered services, which include but are not limited to mental health, substance use, dental and any other benefits delivered through the Medi-Cal FFS by ambulance, litter van, wheelchair van, or air.

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
Non-Medical Transportation (NMT)	Roundtrip transportation to one's IEHP or Delegate-approved medical appointment and/or Medi-Cal covered services, which include but are not limited to mental health, substance use, dental and any other benefits delivered through the Medi-Cal Fee-For-Service by private car, taxi or bus, when the Member has reasonably exhausted other transportation resources.
Non-Physician Practitioner	Licensed providers of service that render limited medical services within their scope of license. Includes nurse practitioners (NP); physician assistants (PAs) and certified nurse midwives (CNMs).
Non-State Program	Any program where IEHP contracts with an employer group to render medical services for its employees.
NPDB	National Practitioner Data Bank; Department of Health and Human Services (DHHS) agency that collects and disseminates information on adverse licensure actions, clinical privilege actions and professional membership actions taken against physicians and dentists; used for credentialing purposes.
NPPES	CMS National Plan and Provider Enumeration System.
Nurse Advice Line	A twenty-four (24) hour triage service provided to Members to help them with decisions regarding appropriate levels of medical care.
Nx Transactions	A set of transactions developed by the National Council for Prescription Drug Programs (NCPDP), that provides record of payment by a plan supplemental to Part D, to a Part D Plan.
ODAG	Organization Determinations, Appeals and Grievances
OIG	Office of Inspector General
Organization Determination	Any decision made by the health plan or the IPA regarding: authorization or payment for a health care item or service; the amount the health plan requires a Member to pay for an item or service; or a limit on the quantity of items or services.
Organizational Provider	Organizational provider: refers to facilities providing services to members and where members are directed for services rather than being directed to a specific practitioner. This element applies to all organizational providers with which the organization contracts (e.g. telemedicine providers, urgent care centers).,
P3	Pre-Existing Pregnancy Program; formally known as Third Trimester Pregnancy Program (TTPP); an IEHP Program that compensates Providers for the financial impact of providing services to a pregnant Member assigned to a Provider late in the pregnancy.
PBM	Pharmacy Benefit Manager
P&T Subcommittee	Pharmacy and Therapeutic Subcommittee; Established by IEHP to oversee the quality of care provided to Members; P&T Subcommittee is a subcommittee of the QM Committee and is responsible for the overall formulary, related prescribing and usage patterns and activities.

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
PAC	Provider Advisory Council; one of seven committees developed by IEHP to oversee the quality of care provided to Members; the PAC addresses issues concerning the IEHP network.
Palliative Care	Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. This involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.
Patterns of Non-Compliance	Timely Access to Care standards set forth in Title 28 California Code of Regulations (CCR) § 1300.67.2.2(c). For purposes of the Provider Appointment Availability Survey: Fewer than 70% of the network providers, as calculated on the Provider Appointment Availability Survey Results Report Form, for a specific network had a non-urgent or urgent appointment available within the time-elapsed standards set forth in subsection (c)(5)(A)-(F) for the measurement year. A pattern of non-compliance shall be identified using the information reported to the Department in the "Rate of Compliance Urgent Care Appointments (All Provider Survey Types)" field and the "Rate of Compliance Non-Urgent Appointments (All Provider Survey Types)" field in the Summary of Rate of Compliance Tab of the Results Report Form.
PARS	Physical Accessibility Review Survey; a facility site review assessment that is required of all PCPs, high volume specialists and designated high volume ancillary sites by the California Department of Health Care Services and Medi-Cal Managed Care Division.
PCP	Primary Care Provider; provides coordinated treatment of assigned Members; generally serves as the Member's "gatekeeper" for managed care plans. A physician responsible for supervising, coordinating, and providing initial and primary care to patients and serves as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). In rural areas, where PCP coverage is limited, Members may be assigned to a Nurse Practitioner at the discretion of IEHP.
Peer	An appropriately trained and licensed Physician in a practice similar to that of the affected Physician.
Peer Review Subcommittee	Peer Review Subcommittee; one of seven committees established by IEHP to provide peer review and other quality related review of practitioners; Peer Review Subcommittee is a subcommittee of the QM Committee and addresses Member or Provider grievances, appeals and practitioner-related quality issues.
PER	Pharmacy Exception Request forms; used to request authorization for use of non-formulary drugs.

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
Per Diem	Payment to Hospitals contracting with IEHP under a "Per Diem Agreement"; a rate paid per day for services rendered regardless of actual charges.
Persons with Disabilities Workgroup (PDW)	An IEHP workgroup, which consists of IEHP Members with disabilities and/or their designee(s), and representatives from community based organizations. This workgroup provides the health plan with recommendations on the provision of health care services, educational priorities, communication needs, and the coordination of and access to services for Members with disabilities.
PET	Performance Evaluation Tool; a tool used by IEHP during contract renewal to evaluate the overall performance and compliance of IPAs against IEHP requirements; outcome determines contract renewal period, type of contract, or non-renewal, if applicable.
Photocopied signature	A signature reproduced provided that the copy must be of an original document containing an original handwritten signature.
PIA	Prison Industry Authority; a system of employment for inmates in California's prisons; used by the State and IEHP for making prescription lenses.
P4P	Pay For Performance formerly Physician Incentive Program (PIP); an incentive program introduced in 2000 that provides PCPs with additional compensation directly from IEHP for specific services rendered to Members. Replaces former Immunization Program.
Plan-to-Plan Contract	An arrangement between two plans, in which the subcontracted plan makes network Providers available to primary plan Members and may be responsible for other primary plan functions. Plan-to-plan contracts include administrative service agreements, management service agreements or other contracts between a primary and subcontracted plan.
PMPM	Per Member Per Month; refers to a method of calculation reimbursement or expense, such as stop loss, based on each Member for one month.
PPC	Provider Preventable Conditions, which include both "Health Care Acquired Conditions (HCACs)" and "Other Provider Preventable Conditions (OPPCs), which are defined as conditions that: 1) are identified by the State Plan; 2) are reasonable preventable through the application of procedures supported by evidence-based guidelines; 3) have negative consequence for the beneficiary, 4) are auditable; and 5) include, at minimum, wrong surgical or other invasive procedure performed on a patient, performed on the wrong body part, or performed on the wrong patient.
PPPC	Public Policy Participation Committee; one of seven committees developed by IEHP to oversee the quality of care provided to Members; PPPC is a Member based Committee responsible for addressing IEHP structural or operational issues that can potentially impact delivery of care.
PQI	Potential Quality Incident

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
Practitioner	Any Medical Physician practicing medicine (i.e. PCPs/Specialists) or non-physician practicing medicine (i.e. Physician Assistants, Nurse Practitioners, Certified Nurse Midwives, Occupational Therapist, Speech Therapist, or Physical Therapist.
Practitioner Profile	A form required by IEHP for submitting credentialed practitioners to IEHP for inclusion in the IEHP network; includes key practitioner demographic information and qualifications.
Preventive Care	Means health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of a full service plan includes but is not limited to all of the basic health care services required by subsection (b)(5) of Section 1345 of the Act, and Section 1300.67 (f) of Title 28.
Primary Plan	A licensed plan that holds a contract with a group, individual subscriber, or a public agency, to arrange for the provision of health care services.
Provider	Any Health Care Provider (i.e. PCP, Specialists, OB/GYN, Behavioral Health, Vision, or Ancillary Providers).
Provider Team	Provider Team; triage unit established by IEHP to resolve Provider and Member issues concerning delivery of care to Members and to address Provider's questions.
PSR	Provider Services Representative; IEHP employee responsible for resolving Provider issues.
PSV Documentation Methodology	The organization may use an electronic signature or unique electronic identifier of staff to document verifications (to replace the dating and initialing of each verification) if it can demonstrate that the electronic signature or unique identifier can only be entered by the signatory. The system must identify the individual verifying the information and the date of verification
Psychiatric Emergency Medical Condition	A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: (1) An immediate danger to himself or herself or to others; or (2) Immediately unable to provide for, or utilize food, shelter or clothing, due to the mental disorder.
Public Health Emergency	The Secretary of Department of Health and Human Services (DHHS) may determine that a disease or disorder presents a public health emergency; or that a public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. These declarations last for the duration of the emergency or ninety (90) days but may be extended by the Secretary
QIO	Quality Improvement Organization
QM	Quality Management; the continuous monitoring of all aspects of health care being administered to IEHP Members.

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
QM Committee	Quality Management Committee; This Committee directs the monitoring of all aspects of health care provided to Members.
QPN	Quality Program Nurse; IEHP employee responsible for monitoring quality management at PCP offices, IPAs and Hospitals.
RA	Remittance Advice: A statement that describes the service payments and adjustments that is included in IEHP Provider reimbursements.
Reconsideration	The first level in the Part C appeal process, which involves the review of adverse organization determination.
Redetermination	The first level in the Part B & Part D appeal process in which the health plan reviews adverse Part B & Part D coverage determination, including the findings upon which the decision was based and any other evidence submitted or obtained.
Residency Clinic	Clinics that operate full-time (Monday to Friday, approximately 8:00am to 5:00pm) as sites for the training of residents in a primary care discipline from an accredited residency training program.
Rural Health Clinic	A clinic that is located in a rural area designated by the Department of Health Care Services as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases, and meets all other requirements.
Scanned signature	A written signature that's been scanned into an electronic format, like a PDF.
Semi-Annually	Twice yearly; used interchangeably with bi-annual.
Service Animal	Any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. This includes guide dogs, signal dogs, or other dogs individually trained to provide assistance to a person with disability.
SFTP	Secure File Transfer Protocol

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
Shared Risk	Shared risk contracting is often used to describe the situation where a health plan enters into a capitation agreement with an independent physician association (IPA) to render professional and outpatient ancillary services, but does not enter into a capitation arrangement with a hospital for "institutional " risk. In these situations, the health plan shares the institutional risk with the IPA. A matrix is created to illustrate the Division of Financial Responsibility (DOFR) between IPA and health plan. This matrix is used as a guide to identify the appropriate party that is financially responsible for covered services. The IPA is paid a capitated amount for the services they are responsible for financially. A budget is established for the institutional risk. Surpluses and deficits to the budget are shared between IEHP and the IPA.
Signature stamp	Is an implement personalized with an individual's name for a quick and easy authorization of documents. These stamps can come customized with just a signature or can include both a signature and printed name.
SNF	Skilled Nursing Facility; a facility, either freestanding or part of a hospital, that accepts patients in need of rehabilitation and medical care that is of lesser intensity than that received in a hospital.
Specialty Care Center	A center that is accredited or designated by the State or federal government, or by a voluntary national health organization, as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.
Specialty Mental Health Services	Behavioral health services provided by Riverside and San Bernardino County Behavioral/Mental Health Plans for individuals (ages 21 and older) for Medi-Cal Members who meet county Tier III Specialty Mental Health criteria.
SSA	Social Security Administration
SSI	Supplemental Security Income
Staff privileges	any arrangements under which a licentiate can practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services
Standing Referral	A referral by a Primary Care Provider (PCP) to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the PCP having to provide a specific referral for each visit.
State Program	Any program administered and/or funded by any federal, state or local county agency that does not involve an employer group; specifically, Medi-Cal or Open Access Program Members.

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
Step Therapy	A process specifying the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. IEHP may require the enrollee to try one or more drugs to treat the Member's medical condition before covering the drug for the condition pursuant to a step therapy request
Stop-Loss	Insurance coverage provided by a third party that pays in event of unexpected financial loss.
Subcontracted Plan	A licensed plan or specialized plan that is contracted to allow a primary plan's Members access to the subcontracted plan's network Providers. The contract may be between the primary plan and the subcontracted plan or between two subcontracted plans.
Subdelegate	If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a subdelegate. The Delegate will be responsible for sub-delegation oversight. Ongoing Monitoring or data collection and alert service are NOT seen as delegation. If information is gathered from a company website and the Delegate staff is pulling the queries for OIG or other types of queries, it is NOT considered delegation.
Substantial Harm Incident	(1)Substantial harm means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss; (2) health care services need not be recommended or furnished by an in-plan provider, but may be recommended or furnished by any health care provider practicing within the scope of his or her practice; and (3) health care services shall be recommended or furnished at any time prior to the inception of the action, and the recommendation need not be made prior to the occurrence of substantial harm.
Terminally Ill	This means that an individual has a medical prognosis that his or her life expectancy is six (6) months or less if the illness runs its normal course.
TTY	Teletypewriter Device for the Hearing Impaired; formally known as Telephone Teletypewriter (TTY); an interpretive tool used to allow hearing impaired Members to access services or care by telephone.
TPA	Third Party Administrator; an administrative organization other than the health plan; Provider or provider of service that collects premiums, pays claims and/or provides administrative services.
TPL	Third Party Liability; another party that has the obligation to cover all or any portion of the medical expense incurred by a Member at the time such services was delivered; usually involving tort liability of another insurance-based entity such as workers' compensation or automobile insurance.
TPL	Therapeutic Pharmaceutical Lacrimal

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
TPG	Therapeutic Pharmaceutical Glaucoma
TLG	Therapeutic Lacrimal Glaucoma
TPA	Therapeutic Pharmaceutical Agent
TOC	Transition of Care; A system of coordinating the delivery of care across all healthcare settings, Providers and services to ensure that all Members moving from one level of care to the next level receive appropriate coordination of care.
TRHCA	Tax Relief and Health Care Act of 2006
Triage or Screening	Means the assessment of an enrollee's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care, for the purpose of determining the urgency of the enrollee's need for care.
Triage or Screening Waiting Time	Means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care.
TrOOP	True Out-of-Pocket
Two-Plan Model Managed Care Program	Developed by DHCS to transfer delivery of Medi-Cal medical care to capitated managed care programs; thirteen counties participate in the program, which consists of a commercial (mainstream) plan and a county public/private partnership (local initiative) plan.
UM	Utilization Management; delegated to IPA; performs oversight of authorization processes and review of Member usage of services for continuous quality improvement.
UM Subcommittee	Utilization Management Subcommittee; Delegated by the Quality Management Committee to direct the continuous monitoring of utilization management activities related to outpatient and inpatient Utilization Management and Behavioral Health program, including the development of appropriate clinical criteria.
Urgent Care	Means health care for a condition which requires prompt attention, consistent with subsection (h)(2) of Section 1367.01 of the Act.
Using the Internet for Primary Source Verification (PSV)	PSV on documents that are printed/processed from an internet site (e.g. BreEZe, National Practitioner Data Bank (NPDB) etc.), the data source date (as of date, release date) must be queried within the timeframe. The date of the query must be verified prior to the Credentialing Decision. If there is no data source date, the verifier must document the review date on the verification or the checklist. Verification must be from a National Committee for Quality Assurance (NCQA) approved and appropriate state-licensing agency.

26. QUICK REFERENCE

B. Glossary

TERM	*DEFINITION*
USPSTF	United States Preventive Services Task Force; An independent, volunteer panel of national experts in prevention and evidence-based medicine that makes recommendations about clinical preventive services such as screenings, counseling services, and preventive medications.
Utilization	The frequency with which a service is used.
Verbal Verification	Requires a dated, signed document naming the person at the primary source who verified the information, his/her title, the date and time of verification and include what was verified verbally.
Verification Time Limit (VTL)	National Committee for Quality Assurance (NCQA) counts back from the decision date to the verification date to assess timeliness of verification. For web queries, the data source data – e.g. release date or as of date is used to assess timeliness of verification.
VFC	Vaccines for Children Program; a federally funded state program providing PCPs with free vaccines for administration to eligible children.
Waste	Waste includes overuse of services, or other practices that, directly or indirectly, results in unnecessary cost. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources (i.e., extravagant careless or needless expenditure of healthcare benefits/services).
WIC	Supplemental Food Program for Women, Infants and Children; a state program for eligible Members which provides nutrition assessments, education, counseling, coupons for food supplements and links to community resources.
Written Verification	Requires a letter or documented review of cumulative reports. IEHP must use the latest cumulative report, as well as periodic updates released by the primary source. The date on which the report was queried, and the volume used must be noted.

26. QUICK REFERENCE

C. Index

26. QUICK REFERENCE

C. Index

26. QUICK REFERENCE

C. Index

26. QUICK REFERENCE

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26. QUICK REFERENCE

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C. Index

26. QUICK REFERENCE

C. Index