# 25. QUICK REFERENCE

## A. Quick Reference Guide

**IEHP Quick Reference Guide**

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| Main Number: | (909) 890-2000 |
| Main Fax Number: | (909) 890-2002 |
| Provider Services Support Team: | (909) 890-2054 |
| Provider Relations Fax: | (909) 890-5652 |

Eligibility:

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| IVR Number: | (888) 440-4340 (24 hrs./ 7 days) |
| Local IVR Number: | (909) 890-3800 (24 hrs./ 7 days) |
| Provider Eligibility Line: | (866) 222-IEHP (4347) |

Member Services:

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| IEHP Member Services Support: | (800) 440-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) |

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| Hours of Operation: | Monday – Friday | 8:00 a.m. - 5:00 p.m. |
| IEHP's UM Staff and Physicians: (Provider inquires regarding authorization request, status and clinical decision and process) | Monday – Friday | 8:00 a.m. - 5:00 p.m. |

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| IEHP Web Site: | www.iehp.org |
| Provider Relations Team Email: | ProviderServices@iehp.org |

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

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

# 25. QUICK REFERENCE

## B. Glossary

| *TERM* | *DEFINITION* |
|---|---|
| **AAO** | American Academy of Ophthalmology. |
| **AAP** | American Academy of Pediatrics; national entity that issues guidelines on preventive services and other care guidelines for children; DHCS contract mandates that the preventive guidelines be followed by IEHP network PCPs. |
| **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. |
| **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. |
| **ADAAG** | Americans with Disabilities Act Access Guidelines; establishes design requirements for the construction and alteration of facilities in the private and public sectors. |
| **ADHC** | Adult Day Health Care Center; see CBAS (Community Based Adult Services). |
| **ADL** | Activities Daily Living |
| **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. |
| **AEVS** | Automated Eligibility and Verification System; DHCS phone system to verify eligibility for Medi-Cal recipients. |
| **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. |
| **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. |

# 25. QUICK REFERENCE

## B. Glossary

| *TERM* | *DEFINITION* |
|---|---|
| **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. |
| **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 Physician (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. |
| **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. |
| **Benefit Year** | The benefit year for Medi-Cal Members is July 1st through June 30th, annually. |
| **BHICCI** | Behavioral Health Integration Complex Care Initiative |
| **BHT** | Behavioral Health Therapy |
| **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. |
| **CAP** | Corrective Action Plan; written plan by a Provider 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. |

| *TERM* | *DEFINITION* |
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| **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. |
| **CBO** | Community Based Organization; an entity providing resources and information on various programs, e.g., Catholic Services. |
| **CCS** | California Children's Services; State program that is locally administered which provides diagnostic services, medical treatment and case management services for eligible children. |
| **CDC** | Centers for Disease Control Prevention |
| **CDL** | Contact Drug List |
| **CDS** | Controlled Dangerous Substance; similar to DEA certification; an authorization issued to physicians writing prescriptions for controlled substances; used for credentialing purposes. |
| **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** | Case Management; a process whereby covered persons with specific health care needs are identified and a plan which efficiently utilizes health care resources is formulated and implemented to achieve the optimum patient outcome in the most cost-effective manner. |
| **CMS** | Centers for Medicare and 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 and Medicaid Services health insurance information collection requirements |
| **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 duplicate coverage whereby the total cost of care for the Member either paid or reimbursed does not exceed 100%. |

| *TERM* | *DEFINITION* |
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| **Code 1 Medications** | Medications that are restricted to specified medical conditions, age group, and/or other specific circumstances. |
| **COE** | Center of Excellence |
| **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). |
| **Complex Case Management** | The systematic coordination and assessment of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. |
| **Comprehensive Medical Case Management Services** | Services provided by a Primary Care Provider in collaboration with the Contractor to ensure the coordination of Medically Necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules and the continuity of care for Medi-Cal enrollees. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs. |
| **Covered Services** | Vision care services and materials that are described as benefits in the Member's Handbook and EOC. |
| **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. |
| **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. |

| *TERM* | *DEFINITION* |
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| **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. |
| **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. |
| **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. |
| **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. |
| **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. |
| **Dispensing Fee** | The amount a doctor is paid for providing materials to a Member. The dispensing fee covers the fitting and dispensing of lenses and/or frames. |
| **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. |
| **DPA** | Diagnostic Pharmaceutical Agent; a state certificate that grants the privilege to Optometrists to use certain medications for diagnostic purposes. |
| **DPSS** | Department of Public Social Services; State agency responsible for the administration of health and welfare benefits, including eligibility for Medi-Cal. |
| **ED** | Emergency Department. |
| **EFT** | Electronic Funds Transfer; the mechanism by which capitation payments are made electronically to Providers by IEHP. |
| **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. |

| TERM | DEFINITION |
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| **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. |
| **EPSDT** | Early and Periodic Screening, Diagnosis and Treatment Supplemental Services; medically necessary services that may or may not be covered by Medi-Cal; available to Members 21 years of age or younger. |
| **Explanation Codes** | Codes used on the Remittance Advice (RA) to reflect claim adjustments made by IEHP. |
| **FAME** | Fiscal Intermediary Access to Medical Eligibility; a monthly and daily electronic transmission from DHCS, which contains eligibility and demographic data on IEHP Medi-Cal Members. |
| **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. |
| **Formulary** | A continually updated list of medications immediately available to practitioners and Members. It contains information on co-payment requirements and the procedures for obtaining Code 1 and non-formulary medications. |
| **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. |
| **FSR** | Facility Site Review; An assessment of a Primary Care Provider's (PCP) site, performed by a Certified Site Reviewer using state-mandated audit tools, prior to the Provider site participating in Medi-Cal Managed Care |
| **FTP** | File Transfer Protocol; method used to obtain and transmit Member eligibility and encounter data from/to IEHP. |
| **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. |
| **HCAC** | Health Care-Acquired Conditions |
| **HCBS** | Home and Community Based Services Waiver Program; DDS program providing in-home care to Members with developmental disabilities. |
| **HCFA** | (see CMS); |

| *TERM* | *DEFINITION* |
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| **HCFA - 1500 Claim** | (see CMS-1500 Claim Form). |
| **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. |
| **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. |
| **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. |
| **GHPP** | The Genetically Handicapped Persons Program (GHPP) is similar to the California Children's Services (CCS) Program but applies for adults with specific GHPP eligible conditions. |
| **ICD-9-CM** | The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's International Classification of Diseases, Ninth Revision (ICD-9). ICD-9-CM is used to code morbidity data and starting with the data year 1999 ICD-10 is used to code and classify mortality data. The ICD-9-CM is arranged in 17 main chapters. Most of the diseases are arranged according to their principal anatomical site, with special chapters for infective and parasitic diseases; neoplasms; endocrine, metabolic, and nutritional diseases; mental diseases; complications of pregnancy and childbirth; certain diseases peculiar to the perinatal period; and ill-defined conditions. |
| **ICD-10-CM** | International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Clinical Modification. ICD-10-CM is planned as the replacement for ICD-9-CM, volumes 1 and 2. However, the codes in ICD-10-CM are not currently valid for any purpose or uses. There is not yet an anticipated implementation date for the ICD-10-CM. Implementation will be based on the process for adoption of standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). There will be a two year implementation window once the final notice to implement has been published in the Federal Register. |

# 25. QUICK REFERENCE

## B. Glossary

| *TERM* | *DEFINITION* |
|---|---|
| **ICF-DD** | Intermediate Care Facilities for Developmentally Disabled |
| **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 Physician (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). |
| **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; a targeted exam, which assesses medical history and current medical condition of newly enrolled Members. |
| **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 with limited income who are disabled, blind or over the age of 65 with in-home care services. |
| **IMD** | Institution of Mental Disease |
| **IMR** | Independent Medical Review; a process ran 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. |

| *TERM* | *DEFINITION* |
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| **IRC** | Inland Regional Center; agency responsible for providing intervention services through the Early Start Program for children at risk or identified as having developmental disabilities. |
| **IVR** | Interactive Voice Response; IEHP's telephone-accessible Member eligibility verification system. |
| **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. |
| **LEA** | Local Education Agency; school district agencies that provide certain services for Medi-Cal Members. |
| **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. |
| **LOA** | Leave of Absence |
| **LOS** | Length of Stay |
| **Low Vision Aids** | Lenses or optical devices used for those with significant vision loss. Low vision aids may include hand-held magnifiers or other high magnification devices. Members with significant vision loss may be eligible for a low vision aid benefit. |
| **LTAC** | Long Term Acute Care |
| **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. |

| TERM | DEFINITION |
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| **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. |
| **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. |
| **Mandatory Aid Codes** | Group 1 – Family: 01, 02, 08, 0A, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 72, 7A, 7X, 82, 8P, 8R<br>Group 2 – Disabled (Medi-Cal only – Not Medicare Eligible): 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V<br>Group 3 – Aged (Medi-Cal only – Not Medicare Eligible): 10, 14, 16, 1E, 1H |
| **Marketing Materials** | Materials produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to potential enrollees. |
| **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 working families with children, low-income seniors, and people with disabilities. |
| **Medical Home** | A place where a Member's medical information is maintained and care is accessible, continuous, comprehensive and culturally competent. A Medical Home shall include at a minimum: a Primary Care Physician (PCP) who provides continuous and comprehensive care: a physician-directed medical practice where the PCP leads a team of individuals who collectively take responsibility for the ongoing care of a Member; whole person orientation where the PCP is responsible for providing all of the Member's health care needs or appropriately coordinating care; optimization and accountability for quality and safety by the use of evidence-based medicine, decision support tools, and continuous quality improvement; ready access to assure timely preventive, acute and chronic illness treatment in the appropriate setting; and payment which is structured based on the value of the patient-centered medical home and to support care management, coordination of care, enhanced communication, access and quality measurement services. This definition can change to include all standards as set forth in W&I Code 14182(c)(13)(B). |

| *TERM* | *DEFINITION* |
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| **Medically Necessary** | Determined through professional peer review to be necessary and appropriate for vision care according to generally accepted standards of practice within the professional community. The fact that a Provider may prescribe, order recommendation or approve a service or material does not, in itself, deem it Medically Necessary or make the charge a Covered Service. |
| **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.<br><br>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. |
| **Member Handbook** | 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. |
| **MET** | Member Evaluation Tool; The information collected from a health information form completed by beneficiaries at the time of enrollment by which they may self-identify disabilities, acute and chronic health conditions, and transitional service needs. Contractor shall receive the MET from the enrollment broker with the enrollment file and shall use the MET for early identification of Members' healthcare needs. For newly enrolled SPDs beneficiaries Contractor must use the MET as part of the health risk assessment process. |
| **MDS** | Minimum Data Set - used as review or evaluation |
| **MLTSS** | Managed Long-Term Services and Supports |
| **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. |

| *TERM* | *DEFINITION* |
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| **MSSP** | Multipurpose Senior Services Waiver Program; a State program providing in-home care to Members as an alternative to institutionalization. |
| **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. |
| **NDC** | National Drug Code |
| **NF** | Nurse Facility |
| **NOA** | Notice of Action |
| **Non-Emergency Medical Transportation** | Ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22 CCR Sections 51323, 51231.1, and 51231.2, rendered by licensed providers. |
| **Non-Mandatory Aid Codes** | Group 1 – Family: 03, 04, 06, 40, 42, 45, 46, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4T, 5K, 7J<br>Group 2 – Disabled (Medi-Cal/Medicare eligible): 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V<br>Group 3 – Aged (Medi-Cal/Medicare eligible): 10, 14, 16, 1E, 1H |
| **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. |
| **NQTL** | Non-Quantitative Treatment Limits |
| **Nurse Advice Line** | A twenty-four (24) hour triage service provided to Members to help them with decisions regarding appropriate levels of medical care. |
| **OIG** | Office of Inspector General |

| *TERM* | *DEFINITION* |
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| **OON** | Out of Network |
| **Organizational Provider** | Any facility or entity providing inpatient, outpatient or home care services to Members; includes at a minimum, hospitals, ASCS, SNFs, HHAs, family planning clinics. |
| **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. |
| **P&T Subcommittee** | Pharmacy and Therapeutic Subcommittee; one of seven committees 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. |
| **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. |
| **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 Physician; 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). For SPD beneficiaries, a PCP may also be a specialist or clinic in accordance with W&I Code 14182 (b)(11).<br>In rural areas, where PCP coverage is limited, Members may be assigned to a Nurse Practitioner at the discretion of IEHP. |
| **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 Diem** | Payment to Hospitals contracting with IEHP under a "Per Diem Agreement"; a rate paid per day for services rendered regardless of actual charges. |

| *TERM* | *DEFINITION* |
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| **Person-Centered Planning** | A highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-centered planning is an integral part of Basic and Complex Case Management and Discharge Planning. |
| **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 provisions 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. |
| **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); new incentive program introduced in 2000 that provides PCPs with additional compensation directly from IEHP for specific services rendered to Members. Replaces former Immunization Program. |
| **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 |
| **Practitioner** | A physician, non-physician medical practitioner, or other Provider of Service. |

| *TERM* | *DEFINITION* |
|---|---|
| **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. |
| **Prescription Drug Prior Authorization or Step Therapy Exception Request Form (RxPA)** | Submission of this specific universal form to request for prior authorization of all non-formulary drugs is required for the Medi-Cal lines of business. |
| **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. |
| **Provider** | With an uppercase "P"; entity directly contracted with IEHP, i.e., IPA or Hospital; with a lowercase "p"; provider of service or entity providing services to IEHP Members. |
| **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. |
| **QM** | Quality Management; the continuous monitoring of all aspects of health care being administered to IEHP Members. |
| **QM Committee** | Quality Management Committee; one of seven committees developed by IEHP to oversee the quality of care provided to Members; the QM Committee monitors and addresses 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. |
| **QTL** | Quantity Treatment Limitations |
| **RA** | Remittance Advice: A statement that describes the service payments and adjustments that is included in IEHP Provider reimbursements. |
| **Semi-Annually** | Twice yearly; used interchangeably with bi-annual. |

| TERM | DEFINITION |
|---|---|
| **Service Authorization Request** | A Member's request for the provision of a Covered Service. |
| **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. |
| **SPD** | Seniors and Persons with Disabilities; Medi-Cal beneficiaries who fall under specific Aged and Disabled aid codes as defined by the department (See Eligible Beneficiary). |
| **SRAE** | Serious Reportable Adverse Events |
| **Standing Referral** | A referral by a Primary Care Physician to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care physician 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. |
| **Stop-Loss** | Insurance coverage provided by a third party that pays in event of unexpected financial loss. |
| **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. |

| TERM | DEFINITION |
|---|---|
| **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. |
| **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. |
| **UCR** | Usual, Customary and Reasonable Fee; The "usual" charge is the fee usually charged for a given service or material, by a Provider, to their private patients. A charge is "customary" when it is within the range of the usual fees charged by the Providers of similar training and experience, for the same service or material as determined by IEHP through its professional review process. The charge is "reasonable" when it meets the above two criteria or is justifiable as determined by IEHP through its professional review process in consideration of special circumstances of a particular case. |
| **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; One of seven committees established by IEHP to oversee the quality of care provided to Member; it is a subcommittee of the QM Committee and continuously monitors all aspects of UM administered to IEHP Members, including medical criteria used in the evaluation of appropriate health care services provided to Members. |
| **Urgent Care** | Means health care for a condition which requires prompt attention, consistent with subsection (h)(2) of Section 1367.01 of the Act. |
| **USPSTF** | United States Preventive Services Task Force |
| **Utilization** | The frequency with which a service is used. |
| **VER** | Vision Exception Request; used to request an exception to the standard benefit and to request authorization for non-covered or non-routine medically necessary vision services or lenses. |

| *TERM* | *DEFINITION* |
|---|---|
| **VFC** | Vaccines for Children Program; a federally funded state program providing PCPs with free vaccines for administration to eligible children. |
| **VSC** | Vision Services Coordinator; responsible for routine and non-routine authorizations through the means of a VER. |
| **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. |

# 25. QUICK REFERENCE

## C. Index

Title | Section
---|---


Access Standards ....................Section 9
Access to Care for People with Disabilities ....................Section 9
Access to Sensitive Services for Minors and Adults ....................Section 9
Access to Specialty Care, Extended....................Section 14
Access, Medical Records – Quality Studies ....................Section 13
Access, OB/GYN Services – Open....................Section 9
Adult Day Health Care Centers (ADHC) ....................Section 12
Adult Preventive Services ....................Section 10
Advance Health Care Directive ....................Section 7
AEVS, Eligibility Verification Method ....................Section 4
AIDS and ARC Waiver Program ....................Section 12
Alcohol and Drug Treatment Services - Medi-Cal Members ....................Section 12
Appeal and Grievance Resolution Process, Physician....................Section 16
Appeal and Grievance Resolution Process, Provider (IPA and Hospital)....................Section 16
Appeals, Claims ....................Section 20
Appeals, Credentialing – Practitioners Denied Participation with IEHP ....................Section 5
Appointments, Missed ....................Section 9
Assignment, PCP ....................Section 3
Audits, Claims....................Section 20
Audits, Focused Referral and Denial ....................Section 14
Audits, Language Competency....................Section 9
Audits, Medical Management....................Section 13
Behavioral Health ....................Section 12
Behavioral Health Services - Medi-Cal Members ....................Section 12
Behavioral Health Treatment (BHT) for Autism Spectrum Disorder…………………. Section 12
Billing of IEHP Members ....................Section 20
California Children Services (CCS) ....................Section 12
Cancer Screening and Treatment Services ....................Section 9
Capitation ....................Section 19
Capitation, Claims Deduction....................Section 20
Care, Coordination of....................Section 12
Care, Long Term....................Section 12
Care, Medical Standards ....................Section 10
Care, Obstetric Certified Nurse Midwives....................Section 10
Care, Pregnant Member – PCP Role....................Section 10
Care Management Requirements - IEHP Monitoring and Oversight ....................Section 12

Title Section

Care Management Requirements - IPA Responsibilities ..........Section 12
Care Management Requirements - PCP Role ..........Section 12
Care Management Requirements - Reporting Requirements ..........Section 12
Care Management Requirements – Continuity of Care .......... Section 12
Care Management Requirements – Identify and Reporting Potential Abuse of IEHP Members.......... Section 12
Care Plan, Individualized..........Section 12
Certified Nurse Midwives, Obstetric Care..........Section 10
Child Safety Programs ..........Section 15
Chaperone Guidance ..........Section 13
Claims Appeals ..........Section 20
Claims Audits ..........Section 20
Claims Deduction from Capitation ..........Section 20
Claims Processing ..........Section 20
Clinics, Residency Teachers ..........Section 6
Clinics, Rural ..........Section 6
Code 1 Medications ..........Section 11
Committee Overview ..........Section 2
Committee, Provider Advisory (PAC)..........Section 2
Committee, Public Policy Participation (PPPC)..........Section 2
Committee, Quality Management..........Section 2
Committees, IEHP ..........Section 1, 2
Communicable Diseases, Reporting to Public Health Authorities..........Section 10
Community Based Adult Services (CBAS) .......... Section 12
Compliance ..........Section 23
Concurrent Review (Utilization Management)..........Section 14
Confidentiality of Medical Records..........Section 7
Consent, Informed..........Section 7
Coordination of Benefits ..........Section 20
Coordination Of Care ..........Section 12
Co-Payment Requirements, Medication..........Section 11
Co-Payments, Member ..........Section 4
Corrective Action Plans (CAPs) ..........Section 13
CPSP Program (Direct Reimbursement for Obstetric Support Services)..........Section 19
Credentialing And Recredentialing ..........Section 5
Credentialing Appeals Process for Practitioners Denied Participation with IEHP ..........Section 5
Credentialing Requirements for Delegated IPAs, Practitioner..........Section 5
Credentialing Requirements for Non-Delegated IPAs, Practitioner..........Section 5

## C. Index

Title Section


Credentialing Subcommittee ....Section 2
Cultural and Linguistic Services ....Section 9
Delegated Activities ....Section 13
Delegation Agreement ....Section 13
Delegation and Monitoring ....Section 13
Denial Audits, and Referral – Focused ....Section 14
Denials, Referrals and Modifications (Utilization Management) ....Section 14
Denied Participation with IEHP, Credentialing Appeals Process for Practitioners ....Section 5
Dental Services ....Section 12
Department of Developmental Services (DDS) ....Section 12
Department of Health Care Services (DHCS) ....Section 12
Developmental Disabilities ....Section 12
Developmental Services, Department of (DDS) ....Section 12
Diabetes Self-Management Program, IEHP ....Section 15
Disabilities, Access to Care for People with ....Section 9
Disabilities, Developmental ....Section 12
Disease Management Program ....Section 12
Discharge Medication Requirements, Hospital Inpatient ....Section 11
Discharge Medications Requirement, Emergency Department ....Section 11
Disclosure and Confidentiality of Medical Records ....Section 7
Disenrollment from IEHP - Involuntary - Member Behavior ....Section 17
Disenrollment from IEHP - Involuntary - Member Status Changes ....Section 17
Disenrollment from IEHP - Voluntary ....Section 17
Disenrollment, Member Transfers ....Section 17
Disputes Between Capitated Relationships ....Section 20
Durable Power of Attorney for Healthcare ....Section 7
Early Start Services and Referrals ....Section 12
Eligible Members ....Section 3
Eligibility File ....Section 4
Eligibility Verification ....Section 4
Eligibility Verification Methods - Eligibility Files ....Section 4
Eligibility Verification Methods – Eligibility Verification Options ....Section 4
Eligibility, Medi-Cal, Loss of PCP Responsibilities ....Section 17
Eligible Members ....Section 3
Emergency Department Discharge Medications Requirement ....Section 11
Encounter Data Reporting ....Section 21
Enrollment And Assignment ....Section 3

# 25. QUICK REFERENCE

## C. Index

Title | Section

Enrollment and Eligibility ....... Section 3
Enrollment Limits, PCP ....... Section 18
Enrollment Process, Medi-Cal ....... Section 3
Episode of Care – Inpatient ....... Section 17
EPSDT Services ....... Section 12
Excluded Services (Chiropractic care, acupuncture, and healing by prayer or spiritual means) ....... Section 12
Extended Access to Specialty Care/Standing Referral ....... Section 14
Facility Site Review and Medical Records Review Requirements and Monitoring ....... Section 6
Facility Site Review ....... Section 6
Family Planning Services ....... Section 10
Finance And Reimbursement ....... Section 19
Financial Viability - Hospital ....... Section 19
Financial Viability - IPA ....... Section 19
Focused Referral and Denial Audits ....... Section 14
Formulary Management ....... Section 11
Fraud Prevention Program ....... Section 23
General ....... Section 1
Genetically Handicapped Persons Program (GHPP) ....... Section 12
Glossary ....... Section 24
Grievance and Appeal Resolution Process, Physician ....... Section 16
Grievance and Appeal Resolution Process, Provider (IPA and Hospital) ....... Section 16
Grievance Resolution Process, Member ....... Section 16
Grievance Resolution System ....... Section 16
Grievances, Urgent Medical – Member ....... Section 16
Guidelines for Obstetrical Services ....... Section 10
Guidelines, IEHP Practitioner ....... Section 5
Health Education ....... Section 15
Health Management Program ....... Section 12
Health Care Services, Department of (DHCS) ....... Section 12
Health Risk Assessment (HRA) ....... Section 12
HIV Testing and Counseling ....... Section 10
Home & Community Based Services (HCBS) Waiver Program ....... Section 12
Hospital Affiliations ....... Section 18
Hospital and IPA Affiliation, Identifying ....... Section 3
Hospital Grievance and Appeal Resolution Process ....... Section 16
Hospital Inpatient and Discharge Medication Requirements ....... Section 11

# 25. QUICK REFERENCE

## C. Index

Title | Section
--- | ---


Hospital Inpatient Medication Requirements ....Section 11
Hospital Limits, PCP ....Section 18
Hospital Network Participation Standards ....Section 18
Hospital Privileges ....Section 5
Hospital, Financial Viability ....Section 19
Identification Cards, Member ....Section 3
Identifying and Reporting Potential IEHP Member Abuse ....Section 12
Identifying IPA and Hospital Affiliation ....Section 3
IEHP Committees ....Section 1, 2
IEHP Monitoring and Oversight, Case Management Requirements ....Section 12
IEHP Network, PCP Sites Denied Participation or Removed From ....Section 6
IEHP Overview ....Section 1
IEHP Practitioner Guidelines ....Section 5
IEHP Quality Oversight of Participating Practitioners ....Section 5
IEHP Service Area ....Section 3
IEHP Terminations of PCPs and Specialists ....Section 18
Immunization Services ....Section 10
Index ....Section 24
Individual Health Education Behavioral Assessments (IHEBAs) ....Section 15
Infection Control ....Section 8
Information Disclosure and Confidentiality of Medical Records ....Section 7
Informed Consent ....Section 7
Initial Health Assessment ....Section 10
Interactive Voice Response (IVR) ....Section 4
Involuntary Disenrollment from IEHP – Member Behavior ....Section 17
Involuntary Disenrollment from IEHP – Member Status Changes ....Section 17
Involuntary Transfers – PCPs ....Section 17
IPA and Hospital Affiliation, Identifying ....Section 3
IPA and PCP Medical Records Requirements ....Section 7
IPA Grievance and Appeal Resolution Process ....Section 16
IPA Limits, PCP ....Section 18
IPA Oversight - Medical Management Audit ....Section 13
IPA Performance Evaluation ....Section 23
IPA Pharmacy Reports ....Section 11
IPA Quality Management Program Structure Requirements ....Section 13
IPA Reported PCP Changes - PCP Termination ....Section 18

# 25. QUICK REFERENCE

## C. Index

Title | Section

IPA Reported PCP Changes - Specialty Practitioner Termination ....Section 18
IPA Responsibilities, Case Management Requirements....Section 12
IPA, Financial Viability....Section 19
IPAs, Delegated – Practitioner Credentialing Requirements....Section 5
IPAs, Non-Delegated – Practitioner Credentialing Requirements ....Section 5
Joint Powers Agency (JPA) Governing Board ....Section 1
Language and Capabilities ....Section 15
Language Competency Audits ....Section 15
Leave of Absence ....Section 18
Long Term Care (LTC) ....Section 12
Loss of Medi-Cal Eligibility - PCP Responsibilities ....Section 17
Mandatory Elder or Dependent Adult Abuse Reporting ....Section 12
Mandatory Domestic Violence Reporting ....Section 12
Management Services Organization (MSO) Changes ....Section 18
Manual Overview ....Section 1
Medical Care Standards ....Section 10
Medi-Cal Eligibility, Loss of PCP Responsibilities ....Section 17
Medi-Cal Enrollment Process ....Section 3
Medical Grievances, Urgent – Member....Section 16
Medical Management Audits, IPA Oversight....Section 13
Medi-Cal Members, Alcohol and Drug Treatment Services ....Section 12
Medi-Cal Members, Behavioral Health Services ....Section 12
Medi-Cal Members, Disenrollment from IEHP – Involuntary....Section 17
Medi-Cal Members, Disenrollment from IEHP – Voluntary ....Section 17
Medi-Cal Members, Pediatric Preventive Services ....Section 10
Medical Records Access, Quality Studies ....Section 13
Medical Records Requirements ....Section 7
Medical Records Requirements, PCP and IPA....Section 7
Medical Records Review Requirements and Monitoring....Section 6
Medical Records, Information Disclosure and Confidentiality ....Section 7
Medication Co-Payment Requirements ....Section 11
Medication Handling Requirements at PCP Sites ....Section 11
Medications, Discharge – Emergency Department ....Section 11
Medications, Hospital Inpatient and Discharge....Section 11
Medications, Non-Formulary – Prior Authorization ....Section 11
Member Behavior – Involuntary Disenrollment from IEHP ....Section 17
Member Billing....Section 20

Title | Section


Member Co-Payments ........ Section 4
Member Eligibility Verification ........ Section 4
Member Enrollment ........ Section 3
Member Grievance Resolution Process ........ Section 16
Member Identification Cards ........ Section 3
Member Rights and Options ........ Section 16
Member Status Changes – Involuntary Disenrollment from IEHP ........ Section 17
Member Transfers and Disenrollment ........ Section 17
Member Urgent Medical Grievances ........ Section 16
Member, Eligibility ........ Section 4
Members' Rights and Responsibilities ........ Section 22
Missed Appointments ........ Section 9
Model Waiver Program ........ Section 12
Multi-Disciplinary Perinatal Services ........ Section 10
Multipurpose Senior Services (MSSP) Program ........ Section 12
Network Changes, PCP ........ Section 18
Non-Discrimination ........ Section 15
Non-Emergency Transportation Services ........ Section 9
Non-Monetary Member Incentive ........ Section 23
Non-Physician Practitioner Requirements ........ Section 6
Nursing Facility (NF) Waiver Program ........ Section 12
OB/GYN Services, Open Access ........ Section 9
Obstetric Care by Certified Nurse Midwives ........ Section 10
Obstetric Care, PCP Provision ........ Section 10
Obstetric Services, Guidelines ........ Section 10
Obstetrical Services - PCP Role in Care of Pregnant Members ........ Section 10
Open Access to OB/GYN Services ........ Section 9
Online Eligibility Verification System ........ Section 4
Online Eligibility Verification System Training Manual ........ Section 4
Organ Transplant ........ Section 12
Organizational Providers, Subcontracted ........ Section 5
Organizational Structure ........ Section 1
Oversight – Medical Management Audits, IPA ........ Section 13
Overview, Committee ........ Section 2
Overview, IEHP ........ Section 1
Overview, Manual ........ Section 1

# 25. QUICK REFERENCE

## C. Index

Title ... Section

Participating Practitioners, IEHP Quality Oversight ... Section 5
Participation Denied with IEHP, Credentialing Appeals Process for Practitioners ... Section 5
Participation Denied, PCP Sites ... Section 6
Pay for Performance (P4P) ... Section 19
PCP and IPA Medical Records Requirements ... Section 7
PCP Changes, IPA Reported – Specialty Practitioner Termination ... Section 18
PCP Changes, IPA Reported PCP Termination ... Section 18
PCP Network Changes ... Section 18
PCP Provision of OB Care ... Section 10
PCP Referral Tracking Log ... Section 14
PCP Responsibilities, Loss of Medi-Cal Eligibility ... Section 17
PCP Role in Care of Pregnant Member – Obstetric Services ... Section 10
PCP Role, Case Management Requirements ... Section 12
PCP Site Reviews (Site Review and Medical Records Review) ... Section 6
PCP Sites Denied Participation or Removed From The IEHP Network ... Section 6
PCP Sites, Medication Handling Requirements ... Section 11
PCP Termination ... Section 18
PCP Termination, IPA Reported and PCP Changes ... Section 18
PCP Terminations, IEHP ... Section 18
PCP/Patient Relationship Database ... Section 3
Pediatric Preventive Services - Medi-Cal Members ... Section 10
Pediatric Weight Loss Program ... Section 15
Peer Review Subcommittee ... Section 2
Performance Evaluation, IPA ... Section 23
Perinatal Services, Multi-Disciplinary ... Section 10
Persons with Disabilities Workgroup (PDW) ... Section 2
Pharmacy ... Section 11
Pharmacy and Therapeutic (P&T) Subcommittee ... Section 2
Pharmacy Reports, IPA ... Section 11
Physician Grievance and Appeal Resolution Process ... Section 16
Pay for Performance (P4P) ... Section 19
Physician Profiling Program ... Section 11
PM 160-Information Only Reporting ... Section 10
POS, Eligibility Verification Method ... Section 4
Post Enrollment Kit ... Section 3
Practitioner Credentialing Requirements for Delegated IPAs ... Section 5

Title ... Section

Practitioner Credentialing Requirements for Non-Delegated IPAs ... Section 5
Practitioner Guidelines, IEHP ... Section 5
Practitioner Requirements, Non-Physician ... Section 6
Practitioners' Rights and Responsibilities ... Section 22
Pre-Existing Pregnancy Program ... Section 19
Preventive Services, Adult ... Section 10
Preventive Services, Pediatric – Medi-Cal Members ... Section 10
Primary Care Physician (PCP) Assignment ... Section 3
Primary Care Physician (PCP) Limits - Enrollment ... Section 18
Primary Care Physician (PCP) Limits - Hospital ... Section 18
Primary Care Physician (PCP) Limits - IPA ... Section 18
Primary Care Physician (PCP) Referrals ... Section 14
Primary Care Physician (PCP) Transfers - Involuntary ... Section 17
Primary Care Physician (PCP) Transfers - Voluntary ... Section 17
Prior Authorization (Utilization Management) ... Section 14
Prior Authorization For Non-Formulary Medications ... Section 11
Program, "Healthy Babies" ... Section 15
Program, Blood Pressure Management ... Section 15
Program, Diabetes Self Management ... Section 15
Program, Family Asthma ... Section 15
Program, Health Management ... Section 12
Program, Healthy Hearts ... Section 15
Program, Hospital Incentive ... Section 19
Program, Pay for Performance (P4P) ... Section 19
Program, Physician Profiling ... Section 11
Program, Pre-Existing Pregnancy ... Section 19
Program, Stop Smoking ... Section 15
Program, Weight Loss ... Section 15
Program, Weight Loss – Pediatric ... Section 15
Program, WIC ... Section 10
Provider (IPA, Hospital, and Practitioner) Grievance and Appeal Resolution Process ... Section 16
Provider Advisory Committee (PAC) ... Section 2
Provider Directory ... Section 18
Provider Network ... Section 18
Provider Preventable Conditions ... Section 13
Provider Resources ... Section 18

# 25. QUICK REFERENCE

## C. Index

Title | Section


Public Policy Participation Committee (PPPC) ....Section 2
Quality Management ....Section 13
Quality Management (QM) Committee ....Section 2
Quality Management Program Structure Requirements, IPA....Section 13
Quality Management Reporting Requirements ....Section 13
Quality Oversight of Participating Practitioners, IEHP....Section 5
Quality Studies Medical Records Access ....Section 13
Quick Reference Guide ....Section 24
Recredentialing and Credentialing....Section 5
Referral and Denial Audits, Focused....Section 14
Referral Tracking Log, PCP ....Section 14
Referral, Standing ....Section 14
Referrals to the Supplemental Food Program for Women, Infants, and Children (WIC) Section 10
Referrals, Denials and Modifications (Utilization Management)....Section 14
Referrals, Early Start....Section 12
Referrals, PCP....Section 14
Reimbursement and Finance....Section 19
Removal From IEHP Network, PCP Sites....Section 6
Reported PCP Changes – PCP Termination, IPA....Section 18
Reported PCP Changes – Specialty Practitioner Termination, IPA ....Section 18
Reporting Communicable Diseases to Public Health Authorities ....Section 10
Reporting Requirements, Case Management Requirements ....Section 12
Reporting Requirements, Quality Management ....Section 13
Reporting Requirements Related to Provider Preventable Conditions (PPC)....Section 13
Reporting Requirements, Utilization Management ....Section 14
Reporting, Encounter Data....Section 21
Requirement, Emergency Department Discharge of Medications ....Section 11
Requirement, Hospital Inpatient and Discharge Medication....Section 11
Requirements and Monitoring, Site and Medical Records Review....Section 6
Requirements and Monitoring, Medical Records and Site Review....Section 6
Requirements, Case Management – PCP Role....Section 12
Requirements, Encounter Data Submission....Section 21
Requirements, IPA Quality Management Program Structure....Section 13
Requirements, Medical Records....Section 7
Requirements, Medical Records, PCP and IPA....Section 7
Requirements, Medication Co-Payment....Section 11

Title | Section


Requirements, Medication Handling at PCP Site ....... Section 11
Requirements, Non-Physician Practitioners ....... Section 6
Requirements, Practitioner Credentialing – Delegated IPAs....... Section 5
Requirements, Practitioner Credentialing – Non-Delegated IPAs ....... Section 5
Requirements, Quality management Reporting....... Section 13
Requirements, Case Management Reporting ....... Section 12
Requirements, Submission (Encounter Data) ....... Section 21
Requirements, Utilization Management Reporting ....... Section 14
Residency Teaching Clinics ....... Section 6
Review Procedures, UM ....... Section 14
Review, Facility Site ....... Section 6
Review, Medical Records ....... Section 6, 7
Rights and Options, Member ....... Section 16
Rights and Responsibilities, Member ....... Section 22
Rural Clinics ....... Section 6
Second Opinions ....... Section 14
Sensitive Services for Minors and Adults, Access ....... Section 9
Service Area, IEHP ....... Section 3
Services, Pediatric Preventive....... Section 10
Services, Adult Preventive....... Section 10
Services, Cultural and Linguistic....... Section 9
Services, Dental ....... Section 12
Services, EPSDT....... Section 12
Services, Excluded....... Section 12
Services, Family Planning ....... Section 10
Services, Immunization....... Section 10
Services, Multi-Disciplinary Perinatal....... Section 10
Services, Non-Emergency Transportation ....... Section 9
Services, Sensitive – Access for Minors and Adults ....... Section 9
Services, Tuberculosis ....... Section 10
Services, Vision ....... Section 12
Sexually Transmitted Infection (STI) Services ....... Section 10
Sites Denied Participation or Removed From the IEHP Network, PCP....... Section 6
Specialist Terminations, IEHP....... Section 18
Specialty Care, Standing Referral/Extended Access ....... Section 14
Specialty Panel ....... Section 18

Title | Section


Specialty Practitioner Termination, IPA Reported PCP Changes ....Section 18
Standards Subcommittee ....Section 2
Standards, Hospital Network Participation....Section 18
Standards, Medical Care ....Section 10
Standing Referral/Extended Access to Specialty Care ....Section 14
Sterilization ....Section 10
Stop Loss ....Section 19
Subcommittee, Credentialing....Section 2
Subcommittee, Peer Review ....Section 2
Subcommittee, Pharmacy and Therapeutic (P&T) ....Section 2
Subcommittee, Standards....Section 2
Subcommittee, Utilization Management ....Section 2
Subcontracted Organizational Providers ....Section 5
Submission Requirements – Encounter Data....Section 21
Submission Requirements ....Section 21
Supplemental Food Program for Women, Infants and Children (WIC), References ....Section 10
Termination, PCP....Section 18
Terminations of PCPs and Specialists, IEHP ....Section 18
Third Party Liability ....Section 20
Total Fracture Care ....Section 10
Transfers and Disenrollment, Member ....Section 17
Transfers, Involuntary – PCPs ....Section 17
Transfers, Members ....Section 17
Transfers, Voluntary, PCPs....Section 17
Transplant, Organ ....Section 12
Tuberculosis Services ....Section 10
UM Review Procedures ....Section 14
Urgent Medical Grievances, Member....Section 16
Utilization Management (UM) ....Section 14
Utilization Management (UM) Subcommittee ....Section 2
Utilization Management Delegation and Monitoring ....Section 14
Utilization Management Reporting Requirements ....Section 14
Vision Services ....Section 12
Voluntary Disenrollment from IEHP....Section 17
Voluntary Transfers – PCPs....Section 17
Waiver Program, AIDS and ARC....Section 12

Title Section

Waiver Program, Home and Community Based (HCBS) ................................................Section 12
Waiver Program, Model.........................................................................................Section 12
Waiver Program, Multipurpose Senior Services, (MSSP)................................................Section 12
Waiver Program, Nursing Facility.............................................................................Section 12
Wheelchair Purchase Referral Procedure ..........................................................Section 14