
14. UTILIZATION MANAGEMENT

A. Review Procedures

1. Primary Care Physician Referrals

APPLIES TO:

- A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

- A. IEHP delegates the responsibility for providing general medical care for Members to Primary Care Physicians (PCPs).
- B. PCPs are responsible for requesting specialty care, diagnostic tests, and other medically necessary services through their IPA’s referral process.
- C. Delegates are responsible for the processing, tracking, and reporting of referrals as specified by IEHP.

PROCEDURES:

- A. Referrals to Specialists, second opinions, elective Hospital admissions, or any services which require prior authorization are initiated by PCPs or Specialists through their IPA. Prior authorization for proposed services, referrals, or hospitalizations involve the following:
 - 1. Verification of Member eligibility by the IPA;
 - 2. Written documentation by the PCP or Specialist of medical necessity for a service, procedure, or referral;
 - 3. Verification by the IPA that the place of service, referred to Practitioner, or Specialist is within the IEHP network; and
 - 4. Assessment of medical necessity and appropriateness of level of care with determination of approval or denial for the proposed service or referral.
- B. PCPs must maintain a Referral Tracking Log for all referrals submitted to IEHP or their IPA for approval in accordance with Policy 14A2, “Review Procedures – Primary Care Physician (PCP) Referral - PCP Referral Tracking Log” (See Attachment, “PCP Referral Tracking Log” in Section 14). The prior authorization/referral process must meet all standards, including timeliness, as delineated in Policy 25E1, “Utilization Management Delegation and Monitoring.” The Referral Tracking Log is reviewed and monitored during Facility Site Review, Medical Record Review Survey and Interim Audits, or as required in accordance with Policy 7A, “PCP and IPA Medical Record Requirements”.
- C. For expedited referrals, Member should receive notice of decision within seventy-two (72) hours of receipt of request. For routine referrals, Member should receive notice of decision within fourteen (14) calendar days.

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A. Review Procedures

1. Primary Care Physician Referrals

- D. The PCP informs Members that if the referral is denied or partially approved (modified), they can file an appeal or grievance with IEHP. A written notice of denial must be provided and include the appeal and grievance process.
- E. Referrals to out-of-network specialists or providers or practitioners require documentation of medical necessity, rationale for the requested referral, and prior authorization from IEHP or the IPA. Once the prior authorization has been obtained, the PCP must continue to monitor the Member's progress to ensure appropriate intervention and assess the anticipated return of the Member to the IEHP network.
- F. Members requiring special tests/procedures or referral to a Specialist, if required by IEHP or the IPA, must first obtain prior authorization through IEHP or the IPA.
1. Each Specialist provides written documentation of findings and care provided or recommended to the PCP within two (2) weeks of the Member encounter.
 2. The PCP evaluates the reports information, initials and dates the report once reviewed, and formulates a follow-up care plan for the Member. This follow-up plan must be documented in the Member's medical record.
 3. The presence of Specialist reports on the PCP's medical records is assessed during periodic chart audits by IEHP.
- G. IEHP reserves the right to perform site audits or to verify the accuracy of information on referral logs by examining source information.
- H. Please refer to Policies 12D1, "Behavioral Health - Behavioral Health Services" and 12D2, "Behavioral Health - Alcohol and Drug Treatment Services" for information on the referral process for behavioral health services.

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14. UTILIZATION REVIEW

A. Review Procedures

2. Primary Care Physician Referral Tracking Log

APPLIES TO:

- A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

- A. All Primary Care Physicians (PCPs) are required to maintain a system for tracking all referrals submitted to their IPA.

PROCEDURES:

- A. All PCPs must maintain a referral log that contains all of the information noted below:
1. Date Referral sent to IPA;
 2. Member name and date of birth;
 3. Acuity of referral;
 4. Reason for referral/diagnosis;
 5. Service or activity requested;
 6. Date authorization received;
 7. Referral decision;
 8. Patient notified;
 9. Date of appointment or service; and
 10. Date consult report received or outreach effort.
- B. PCPs may either use the PCP Referral Tracking Log (See Attachment, “PCP Referral Tracking Log” in Section 14) or another system that contains all of the above-required information.
- C. PCPs must utilize the referral log to coordinate care for the Member, to obtain assistance from their IPA if specialty appointments are delayed, or consultation notes are not received.
- D. Referral logs, or equivalent system, must be available at all times at the PCP site.
- E. Copies of referrals and any received consultation and/or service reports must be filed timely in the Member’s medical record.

14. UTILIZATION REVIEW

A. Review Procedures

2. Primary Care Physician Referral Tracking Log

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14. UTILIZATION MANAGEMENT

A. Review Procedures

3. Standing Referral/Extended Access to Specialty Care

APPLIES TO:

- A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

- A. IEHP and its Delegated IPAs are required to establish and implement procedures for Primary Care Physicians (PCPs) to request a standing referral to a Specialist for a Member who, as a component of ongoing ambulatory care, requires continuing specialty care over a prolonged period of time, or extended access to a Specialist for a Member who has a life threatening, degenerative, or disabling condition that requires coordination of care by a Specialist.
- B. Members with a life-threatening, degenerative or disabling condition or disease must receive a referral to a Specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the Specialist or specialty care center coordinate the Member’s care.
- C. Practitioners that are Board-Eligible in appropriate specialties, e.g., Infectious Disease, are able to treat conditions or diseases that involve a complicated treatment regimen that requires ongoing monitoring. Board certification is verified during the Provider credentialing process. Members may obtain a list of Practitioners who have demonstrated expertise in treating a condition or disease involving a complicated treatment regimen that requires ongoing monitoring by contacting IEHP at (877) 273-4347 or for TTY (800) 718-4347.
- D. PCPs are responsible for coordinating the care of the Member in consultation with the Specialist, IPA and the Member.

PROCEDURES:

- A. IEHP and its Delegated IPAs must develop and implement a procedure for standing referrals or extended access to a Specialist at the Member or PCP request. The PCP and/or Member determines, in consultation with the Specialist and/or the Medical Director or designee, if a Member needs continuing care from a Specialist.
- B. After consultation with the Specialist as needed and the Medical Director, the PCP must submit his/her request for a standing specialty referral or extended access to their IPA in writing, using the designated form (See Attachment, “Standing Referral/Extended Access Referral to Specialty Care” in Section 14). Appropriate medical records must be attached to the request.
- C. Standing referrals are processed according to turnaround timeframes as outlined in Policy 14A, “Utilization Management Delegation and Monitoring”.

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A. Review Procedures

3. Standing Referral/Extended Access to Specialty Care

- D. If IEHP or the IPA determines that the standing referral should be limited in terms of number of visits or timeframe, IEHP or the IPA, in consultation with the PCP and Specialist, must develop a treatment plan specifying the limits.
- E. Standing referrals or extended access to specialty care approved without limitations do not require a treatment plan or IEHP approval.
- F. Potential conditions necessitating a standing referral and/or treatment plan include but are not limited to the following:
1. Significant cardiovascular disease;
 2. Asthma requiring specialty management;
 3. Diabetes requiring Endocrinologist management;
 4. Chronic obstructive pulmonary disease;
 5. Chronic wound care;
 6. Rehab for major trauma;
 7. Neurological conditions such as multiple sclerosis and uncontrollable seizures among others; and
 8. Gastrointestinal (GI) conditions such as severe peptic ulcer and chronic pancreatitis among others.
- G. Potential conditions necessitating extended access to a Specialist or specialty care center and/or treatment plan include but are not limited to the following:
1. Hepatitis C;
 2. Lupus;
 3. HIV;
 4. AIDS;
 5. Cancer;
 6. Potential transplant candidates;
 7. Severe and progressive neurological conditions;
 8. Renal failure; and
 9. Cystic fibrosis.
- H. When authorizing a standing referral to a Specialist for the purpose of the diagnosis or treatment of a condition requiring care by a Physician with a specialized knowledge of HIV medicine the Member must be referred to an HIV/AIDS Specialist.

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A. Review Procedures

3. Standing Referral/Extended Access to Specialty Care

- I. Any medical condition requiring frequent or repeat visits to a Specialist should be considered by the referring Provider for submission of a standing referral or extended access, if the Member requests or the PCP and Specialist determine that continuing care is required..
 1. Upon Member request for a standing referral, the PCP shall make a determination within three (3) business days whether to submit a standing referral to IEHP or the IPA. This determination should be made after consulting with the Member's treating Specialist.
 2. Once a decision is made that a standing referral is needed, the PCP must submit a request for standing specialty referral to IEHP or the IPA within four (4) business days, using the designated form (See Attachment, "Standing Referral/Extended Access Referral to Specialty Care" in Section 14). Appropriate medical records must be attached to the request. A determination will be rendered by IEHP or IPA Medical Director (or designee).
- L. After approval of the request for standing specialty or extended access to specialty care, with or without a treatment plan, the IPAs are required to notify the PCP, Specialist, and Member in writing within regulatory timeframes.
- J. IPAs must forward all denials of requests for standing specialty or extended access to specialty care to IEHP within three (3) business days of the denial. IPAs must also inform the PCP, Specialist, and Member of the denial in writing according to prescribed formats for denials. Please refer to Policy 25E1, "Utilization Management Delegation and Monitoring."
- K. IPAs can require Specialists to provide to the PCP and the IPA written reports of care provided under a standing referral.

Out of Network

- A. IEHP and its Delegated IPAs are not required to refer Members to out-of-network practitioners unless appropriate specialty care is not available within the network.
- B. IEHP and its Delegated IPAs must provide and coordinate any for out-of-network services adequately and timely when such services are medically necessary and not available within the network.
- C. IEHP and its Delegated IPAs must coordinate payment with out-of-network providers and ensure that cost to the Member is not greater than it would be if the services were furnished within the network.

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- A. Review Procedures
 - 3. Standing Referral/Extended Access to Specialty Care
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REFERENCE:

- A. Coordinated Care Initiative (CCI) Three-Way Contract, Section 2.11 eff January 1st, 2018.

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14. UTILIZATION MANAGEMENT

B. Second Opinions

APPLIES TO:

- A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

- A. Primary Care Physicians (PCPs), Specialists, and Members (if the Provider refuses) or their representative, have the right to request a second opinion from their IPA regarding proposed medical or surgical treatments from an appropriately qualified participating healthcare professional acting within their scope of practice who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition, or conditions associated with the request for a second opinion.
- B. Second opinions are authorized and arranged through the Member’s IPA.
- C. The mandated timeframes for decisions of a request for a second opinion and subsequent notification to the Member and Practitioner are available in the Member’s Evidence of Coverage (EOC) and are available to the public, upon request.

PROCEDURES:

- A. The Member’s request for a second opinion is processed through their IPA’s prior authorization system. Members should request a second opinion through their PCP or Specialist. If the PCP or Specialist refuses to submit a request for a second opinion, the Member can submit a grievance or a request for assistance through IEHP Member Services at (877) 273-4347. IEHP’s Member Services staff directs the Member to an IEHP Care Manager. The Care Manager assists the Member in contacting his/her Delegated IPA to request a second opinion.
- B. The PCP or Specialist submits the request for a second opinion to the Member’s IPA including documentation of the Member’s condition and proposed treatment.
- C. If the referral for a second opinion is approved, the IPA authorizes services for the Member to see a Physician in the appropriate specialty. Agreements with any network or out-of-network practitioner for second opinions must include the requirement that the consultation report for the second opinion be submitted within three (3) working days of the visit to the Practitioner.
- D. Request may only be denied if the Member insists on an out-of-network practitioner when there is an appropriately qualified Practitioner in-network. If the referral is denied or partially approved (modified), the IPA provides written notification to the Member, including the rationale for the denial or partial approval (modification), alternative care recommendations, and information on how to appeal this decision.
- E. If there isn’t a Physician within the IEHP network that meets the qualifications for a second

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opinion, the IPA must authorize a second opinion by a qualified Physician outside IEHP's network and ensure that cost to the Member is not greater than it would be if the services were furnished within the network.

- F. IEHP and its Delegated IPAs must provide and coordinate any out-of-network services adequately and timely.
- G. Members disagreeing with the denial of their request for second opinion may appeal through the IEHP Appeal process. Refer to Section 16, "Grievance and Appeal Resolution System" for more information.
- H. In cases where the Member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb or other major bodily function, or lack of timeliness that would be detrimental to the Member's ability to regain maximum function, decisions and notification of decisions to Practitioners are completed in a timely fashion not to exceed seventy-two (72) hours after receipt of request, whenever possible.
- I. In situations where the Member believes that the need for a second opinion is urgent, they can request facilitation by IEHP by contacting IEHP Member Services. IEHP reviews such requests, and if determined to be urgent, facilitates the process by working directly with the PCP and the IPA. If the request is determined by IEHP to be not urgent, the Member is referred back to his/her PCP and IPA to continue the process.
- J. IEHP and its Delegated IPA must utilize a Second Opinion Tracking Log (See Attachment, "Second Opinion Tracking Log" in Section 25) to track the status of second opinion requests and to ensure that the second opinion Provider submits the consultation report within three (3) working days of the visit. The Log must include all authorized, partially approved (modified), and denied second opinions and must be submitted on a monthly basis through IEHP's Secure File Transfer Protocol (SFTP) server, by the 15th of the following month. See Policy 25E2, "Utilization Management - Reporting Requirements" for more information.
- K. Reasons for providing or authorizing a second opinion include, but are not limited to, the following:
 - 1. The Member questions the reasonableness or necessity of recommended surgical procedures;
 - 2. The Member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment including but not limited to a serious chronic condition;
 - 3. Clinical indications are not clear or are complex and confusing, a diagnosis is questionable due to conflicting test results, or the treating PCP/Specialist is unable to diagnose the condition and the Member requests an additional diagnostic opinion;
 - 4. The treatment plan in progress is not improving the medical condition of the Member within an appropriate time period given the diagnosis and plan of care, and the Member

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B. Second Opinions

- requests a second opinion regarding the diagnosis or continuance of the treatment; and
5. The Member has attempted to follow the plan of care or consulted with the initial physician concerning serious concerns about the diagnosis or plan of care.
 - L. If the Member is requesting a second opinion about care received from his or her PCP, the second opinion must be provided by an appropriately qualified Physician of the Member's choice within IEHP's or the IPA's network.
 - M. If the Member is requesting a second opinion about care received from a Specialist, the second opinion must be provided by any Physician with the same or equivalent specialty of within the IPA's network. If not authorized, additional medical opinions obtained from a physician not within IEHP or the IPA's network is the responsibility of the Member.
 - N. The IPA is responsible for submitting a copy of all authorizations, modifications, and denials of second opinions to the PCP.
 - O. The notification to the Practitioner that is performing the second opinion must include the timeframe for completion of the consultation and requirements for submission of the consultation report.
 - P. The second opinion Practitioner is responsible for submitting consultation reports to the Member, requesting Practitioner and PCP within three (3) working days of the visit. If the second opinion is deemed urgent, the submission of the consultation report must be within twenty-four (24) hours of the visit.
 - Q. Behavioral Health (BH) Providers who complete a second opinion evaluation or consultation must submit the "BH Initial Evaluation Coordination of Care Report" to the IEHP BH Department through the secure IEHP Provider portal within three (3) working days of the visit. BH Providers can receive training on how to use the secure IEHP Provider portal or how to complete the Provider web forms by calling the IEHP Provider Relations Team at (909) 890-2054 or emailing providerservices@iehp.org.
 - R. The PCP is responsible for documenting second opinions and monitoring receipt of consultation reports on the PCP Referral Tracking Log (See Attachment, "PCP Referral Tracking Log" in Section 14).
 - S. Mandated timeframes for decision including approval, denial or modification of a non-urgent, urgent or concurrent request for a second opinion and subsequent notification to the Member and Practitioner must follow the timeframes outlined in Policy 25E1, "Utilization Management Delegation and Monitoring."
 - T. IEHP's or the IPA's Medical Director may request a second opinion at any time if it is felt to be necessary to support a proposed method of treatment or to provide recommendations for an alternative method of treatment.

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B. Second Opinions

REFERENCE:

A. Coordinated Care Initiative (CCI) Three-Way Contract, Section 2.11 eff January 1st, 2018.

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14. UTILIZATION MANAGEMENT

C. Emergency Services

APPLIES TO:

- A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare –Medicaid Plan) Members.

POLICY:

- A. Providers must render services to Members who present themselves to an Emergency Department (ED) for treatment of an emergent or urgent condition. Per federal law, at a minimum, services must include a Medical Screening Exam (MSE).
- B. IPAs are responsible for payment of professional services rendered to Members at the ED per their contract with IEHP and this policy. IPAs with a full risk contract are responsible for the facility component. For all other IPAs, IEHP is responsible for the facility and technical services rendered to Members in the ED.
- C. Per regulatory requirements, IEHP uses the following definitions of an emergency medical and psychiatric condition:
1. Emergency medical condition means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
 - a. Placing the health of the individual (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
 - b. Serious impairment to bodily function; or
 - c. Serious dysfunction of any bodily organ or part.
 2. Emergency psychiatric condition means a behavioral health crisis which is manifested by acute psychiatric symptoms such that a prudent layperson who possesses an average knowledge of behavioral health could reasonably expect the absence of immediate intervention to result in:
 - a. Placing an individual at risk for injuring themselves (Danger to Self);
 - b. Placing an individual at risk for injuring others (Danger to Others); or
 - c. Serious impairment in an individual's ability to care for themselves or others (Gravely Disabled).
- D. Medical and Behavioral Health Providers must have internal policies and procedures that delineate what steps are to be taken in the event a Member presents to their office with a medical or psychiatric emergency requiring immediate intervention. These steps should include when office staff or Practitioners should call 911. Providers need to ensure all office staff and Practitioners are trained on how to handle these types of emergencies.

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C. Emergency Services

- E. IEHP and IPA financial responsibilities for the diagnosis and/or treatment of a Member's visit to an ED are delineated in the contractual agreements between IEHP and the IPA.
- F. If it is determined that the Member's condition was not emergent, the Member's IPA is responsible for the MSE, at a minimum based on individual contracts. The Member is not financially responsible and must not be billed for any difference between the amount billed by the Hospital and amount paid by the IPA.
- G. IPAs are encouraged to develop contractual arrangements with EDs and physician groups.
- H. IEHP provides non-contracted facilities in the State of California with specific contact information needed to obtain timely authorization of post-stabilization care for Members.
- I. IEHP and its Delegated IPAs shall make every effort to respond to requests for necessary post-stabilization medical care within thirty (30) minutes of receipt. In the event IEHP or its Delegated IPA does not respond within this timeframe, the services are considered approved.

PROCEDURES:

- A. Prior authorization is not required for the MSE (or COBRA exam) performed at an ED, to the extent necessary to determine the presence or absence of an emergency medical condition, or for services necessary to treat and stabilize an emergency medical condition.
- B. The IPA's payment for associated services must be based on the Member's presentation and the complexity of the medical decision-making, as outlined in the American Medical Association (AMA) Current Procedural Terminology (CPT) Guide under 'Emergency Department Services'.

REFERENCES:

- A. Title 42, Code of Federal Regulations §438.114.
- B. Health & Safety Code §§ 1371.4(a) through (d).
- C. Coordinated Care Initiative (CCI) Three-Way Contract, Section 2.11 eff January 1st, 2018.

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14. UTILIZATION MANAGEMENT

D. Pre-Service Referral Authorization Process

APPLIES TO:

- A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

- A. Primary Care Physicians (PCPs) are responsible for providing general medical care for Members and requesting specialty care, diagnostic tests, and other medically necessary services either through the IPA's or IEHP's referral authorization process.
- B. The PCP must review any referral from an affiliated mid-level Practitioner, i.e. Nurse Practitioner (NP) or Physician Assistant (PA), prior to the submission of the referral. If there are questions about the need for treatment or referral, the PCP must see the Member.
- C. IEHP and its Delegated IPAs must have a process in place to allow a Specialist to directly request authorization from IEHP or the Delegated IPA for additional specialty consultation, diagnostic, or therapeutic services.
- D. IEHP and its Delegated IPA must ensure that decisions to deny or partially approve (modify) (authorize an amount, duration, or scope that is less than requested) are made by a qualified health care professional with appropriate clinical expertise in the condition and disease.
- E. IEHP and its Delegated IPAs should evaluate PCP and Specialist referral patterns for over and underutilization.

PROCEDURES:

- A. The Nurse Practitioner or the Physician Assistant can sign and date the referral form but must document on the form the name of the PCP or Specialist.
- B. Referral forms from the PCP or Specialist must include the following information:
 - 1. Designation of the referral request as either routine or expedited to define the priority of the response. Referrals that are not prioritized are handled as "routine." Referrals that are designated as expedited must include the supporting documentation regarding the reason the standard timeframe for issuing a determination could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function;
 - 2. The diagnosis (ICD) and procedure (CPT) codes;
 - 3. Pertinent clinical information supporting the request; and
 - 4. Signature of referring physician and date. This may consist of handwritten signature, handwritten initials, unique electronic identifier, or electronic signatures that must be able to demonstrate appropriate controls to ensure that only the individual indicated may enter a signature.

14. UTILIZATION MANAGEMENT

D. Pre-Service Referral Authorization Process

- C. Upon receipt of the referral, IEHP and its Delegated IPAs are responsible for verification of Member eligibility and plan benefits.
- D. IEHP and its Delegated IPAs must have a process that facilitates the Member's access to needed specialty care by prior authorizing at a minimum a consult and up to two (2) follow up visits for medically necessary specialty care (See Attachment, "Specialty Office Service Auth Sets Grid" in Section 14).
- E. Prior authorization for medically necessary procedures or other services that can be performed in the office, beyond the initial consultation and up to two (2) follow up visits, should be authorized as a set or unit. For example, when approving an ENT consultation for hearing loss, an audiogram should be approved (See Attachment, "Specialty Office Service Auth Sets Grid" in Section 14).
 - 1. **Exceptions** - Prior Authorization is not required and Member may self-refer for the following services. All other services require prior authorization:
 - a. Family Planning;
 - b. Abortion Services;
 - c. Sexually transmitted infection (STI) treatment;
 - d. Sensitive and Confidential Services;
 - e. HIV Testing and counseling at the Local Health Department;
 - f. Immunizations at the Local Health Department;
 - g. Routine OB/GYN Services, (including prenatal care by Family Care Practitioner (credentialed for obstetrics) within IEHP network;
 - h. Out of area renal dialysis;
 - i. Urgent Care;
 - j. Preventative services;
 - k. Urgent support for home and community service-based recipients; and
 - l. Other services as specified by the Centers for Medicare and Medicaid Services (CMS).
- F. Referrals to out-of-network practitioners require documentation of medical necessity, rationale for the requested out-of-network referral, and prior authorization from the IPA. Once the prior authorization has been obtained, the PCP's office should assist the Member with making the appointment, continue to monitor the Member's progress to ensure appropriate intervention, and assess the anticipated return of the Member into the network.
- G. Decisions for referrals must be made in a timely fashion – not to exceed regulatory turnaround timeframes for determination and written notification of Members and Practitioners (See Attachment, "UM Timeliness Standards – IEHP DualChoice" in Section 14). Decisions to

14. UTILIZATION MANAGEMENT

D. Pre-Service Referral Authorization Process

deny, approve, modify or delay a service authorization request are made within all timeframes that meet regulatory requirements as outlined in Title 42 of the Code of Federal Regulations Sections 438.210, 422.568, 422.570, and 422.572.

- H. IEHP and its Delegated IPAs should monitor the PCP's rate of referrals to Specialists to:
1. Monitor for potential over or under utilization of Specialists; and
 2. Identify referral requests that are within the scope of practice of the PCP.
- I. When IEHP or the Delegated IPA identifies a potential problem with the PCP's referrals to Specialists, interventions need to be implemented that address the specific circumstances that were identified during the monitoring process. Interventions, such as written correspondence to the PCP that addresses the identified concern with supporting policy or contract attached, or the Medical Director contacting the PCP to discuss the concern, should be attempted to help educate the PCP.
- J. There must be documented evidence of the corrective action taken by IEHP or the Delegated IPA, including the PCP's response to the intervention. The PCP's referral pattern must be re-evaluated after a sufficient amount of time (at least sixty (60) days) has elapsed to monitor effectiveness.
- K. Specialists are required to forward consultation notes to the PCP within two (2) weeks of the visit.
- L. For IEHP DualChoice Members that have their Medi-Cal with IEHP, all request for services covered under the Medi-Cal benefit should be faxed to IEHP immediately upon receipt to (909) 890-5751.
- M. In the event a Specialist or sole proprietor is terminated, IEHP or Delegated IPA coordinates the redirection of assigned Members as needed.

REFERENCES:

- A. Title 42, Code of Federal Regulations §§422.568, 422.570, 422.572, and 438.210.
- B. Coordinated Care Initiative (CCI) Three-Way Contract, Section 2.11 eff January 1st, 2018.

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14. UTILIZATION MANAGEMENT

E. Wheelchair Purchase Referral Procedure

APPLIES TO:

- A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

- A. Delegated IPAs with a Global or Shared Risk are responsible for authorizing custom wheelchair purchases on their own behalf.
- B. IEHP and its Delegated IPAs are responsible for authorizing non-custom wheelchair purchases and wheelchair rentals according to their individual contracts.
- C. IEHP requires a thorough functional/safety evaluation performed by an independent third party to determine the medical necessity of custom wheelchair/power wheelchair requests. These evaluations must be performed by a Physiatrist or Qualified Rehabilitation Professional that has no financial relationship with the vendor. If the Delegated IPA does not submit a thorough functional/safety evaluation to support the medical necessity of the custom wheelchair/power wheelchair request, then IEHP will have the option to obtain this at its discretion and will deduct from the Delegated IPA’s capitation payment.
- D. IEHP or Delegated IPA should coordinate a seating evaluation, either facility-based or in-home, for Members who need custom wheelchairs, power wheelchairs, non-routine wheelchair therapeutic seat cushions, and/or wheelchair positioning systems.
- E. IEHP or Delegated IPA is responsible for repairs and maintenance of custom wheelchairs for qualified individuals as per the Delegated IPA’s contract.

PROCEDURES:

- A. Prior to the submission of a request to IEHP for the purchase of a custom wheelchair/power wheelchair, the Member must have a thorough functional/safety evaluation performed by an independent third party such as a Physiatrist or Qualified Rehabilitation Professional, as authorized by the Delegated IPA.
- B. Custom wheelchair/power wheelchair purchase requests that meet Medicare criteria that are processed through a Delegated IPA shall follow the Delegate's prior authorization procedures.
- C. Custom wheelchair/power wheelchair requests that do not meet Medicare criteria are to be forwarded to IEHP via fax to 909-890-5751 as expeditiously as possible for IEHP to review and make a final determination.
 - 1. IEHP will issue the denial letter if the request doesn’t meet Medicare or Medi-Cal criteria. If the request meets Medi-Cal criteria, IEHP will authorize the request under the Medi-Cal line of business.

14. UTILIZATION MANAGEMENT

E. Wheelchair Purchase Referral Procedure

- D. IEHP or Delegated IPA’s Utilization Management (UM) department will review the referral and the supporting documentation to make a determination within the timeframes outlined in the UM Timeliness Standards from the receipt of the referral from the Delegated IPA (See Attachment, “UM Timeliness Standards – IEHP DualChoice” in Section 14).
- E. IEHP will issue denial letters for services denied by IEHP, and the Delegated IPA will issue denials for the services denied by them.
- F. IEHP or Delegated IPA’s UM Department will send notification to the Member, Requesting Provider and Primary Care Physician (PCP).
- G. If approved, IEHP or Delegated IPA will arrange for the Member to be assessed for a seating evaluation, either facility-based or in-home, to determine equipment needs.
- H. Unless otherwise informed, the equipment will be delivered to the Member’s home.
- I. The Seating Evaluator will contact the Member and schedule a post-delivery assessment that will include the Durable Medical Equipment (DME) vendor, as needed.

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14. UTILIZATION MANAGEMENT

F. Long-Term Care (LTC) 1. Custodial Level

APPLIES TO:

- A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

- A. Long-Term Care (LTC) facilities include skilled nursing, adult subacute, pediatric subacute, and other intermediate care units.
- B. Members can be admitted to LTC facilities from acute inpatient settings, transition from skilled level, or as direct admits from the community.
- C. IEHP and/or Delegated IPAs are financially responsible for one hundred (100) skilled nursing days per benefit period for IEHP DualChoice Members. Please see Policy 14F2, “Long-Term Care (LTC) - Skilled Level” for more information.
- D. Delegated IPAs are responsible for notifying IEHP of Members who require admission to LTC/custodial facilities as direct admits from the community and if the admission to LTC facility is after an acute hospital admission.
- E. Delegates are responsible for coordinating with IEHP the provision of all necessary care coordination for Members in LTC facilities.
- F. IEHP and IPAs are responsible for notifying Members and LTC/custodial facilities that IEHP DualChoice LTC benefits expire after one hundred (100) days of inpatient skilled nursing care per benefit period. Please see Policy 14F2, “Long-Term Care (LTC) - Skilled Level” for more information.

PURPOSE:

- A. To promote the appropriate placement of Members into long-term care when services cannot be provided in environments of lower levels of care or as an appropriate plan of transition from the hospital.
- B. To ensure all nursing facilities and subacute facilities comply with all regulatory guidelines, including care coordination, which will be facilitated by IEHP.
- C. To promote the transition of Members back into the community, as appropriate.

PROCEDURES:

- A. IEHP will become financially responsible for facility fees once it has been determined that the Member requires a custodial level of care or when the allotted one hundred (100) skilled days have been exhausted. The Delegated IPA remains responsible for professional fees

14. UTILIZATION MANAGEMENT

F. Long-Term Care (LTC) 1. Custodial Level

for the month of initial enrollment into the plan/IPA and admission to custodial care and month following.

- B. Please refer to the Medi-Cal Provider Manual for information on custodial care under Medi-Cal.
- C. Add-on accommodation codes do not apply to custodial level of care, unless otherwise indicated by IEHP's Medical Director for a limited period.

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14. UTILIZATION MANAGEMENT

- F. Long Term Care
 - 2. Skilled Level
-

APPLIES TO:

- A. This policy applies for all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

- A. IEHP is responsible for performing all aspects of non-delegated utilization management and care management (CM) responsibilities related to Long Term Care (LTC) skilled level placement. IEHP will follow active Members while in an LTC facility.
- B. IEHP DualChoice Members do not need a three (3) day acute hospital stay prior to admission to an LTC.

PURPOSE:

- A. To promote the appropriate placement of Members into long term care when daily skilled nursing or rehabilitation services cannot be provided in environments of lower levels of care, or as an appropriate plan for discharge from the Hospital.
- B. To ensure all nursing facilities and subacute facilities comply with all regulatory guidelines, including care coordination which will be facilitated by IEHP.

PROCEDURES:

- A. Appropriate LTC skilled level placement involves the following factors:
 - 1. The Member requires skilled nursing services or skilled rehabilitation services on a daily basis.
 - 2. Only contracted LTCs are utilized unless none are available, then a letter of agreement (LOA) is requested.
 - 3. The Member's eligibility and schedule of benefits are verified prior to authorizing appropriate services. Within the first five (5) days of each month, eligibility is re-evaluated for Members remaining in LTC from the prior month.
- B. Primary Care Physicians (PCPs) must evaluate a Member's need for LTC skilled level placement. A referral request must be submitted to the Member's Delegated IPA with sufficient medical information from the Member's PCP for review and recommendation when transitioning from community or usual setting.
 - 1. For non-delegated UM performed by IEHP, if the Member is in an acute facility, physician orders with treatment modalities may be documented in the medical record or appropriate forms and discussed with UM staff in lieu of a referral being generated.
- C. Delegated IPAs are required to have a similar process for review and authorization of requests for LTC skilled level placement from home.

14. UTILIZATION MANAGEMENT

F. Long Term Care 2. Skilled Level

- D. All the clinical reviews, the discharge date, and discharge needs must be received from the facility in order for the entire stay to be authorized.
- E. Authorization details will be available for the facility to view on IEHP's secure Provider portal once facility face sheet, admission orders, MC171 form, and if indicated, inter-facility transfer form have been received by IEHP.
- F. Concurrent review is performed at least weekly, unless directed otherwise by the Long-Term Care Review Nurse, until discharge. Concurrent review may be performed either through on-site chart review or telephonically.
- G. Reviews should include physician communication and ongoing communication with other healthcare professionals involved in the Member's care as necessary. Authorization decisions must be made within forty-eight (48) hours of receipt of request.
- H. Adequate information must be available to determine the appropriate level of care including:
 - 1. The Member's level of function and independence prior to admission and currently;
 - 2. Caregiver/family support;
 - 3. Skilled care is required to achieve the Member's optimal health status;
 - 4. Around-the-clock care or observation is medically necessary;
 - 5. The realistic potential and timeline for the Member to regain some functional independence;
 - 6. Information obtained from Physical Therapy, Occupational Therapy, and Speech Therapy Departments, as necessary;
 - 7. Expected outcome of the Member's health status with LTC skilled level placement is obtained through weekly reviews from the facility, unless directed otherwise by IEHP or Delegated IPA's Case Management, for clinical updates, status of goals, and discharge planning (See Attachments, "Long Term Care (LTC) Initial Review Form" and "Long Term Care (LTC) Follow-up Review Form" in Section 14); and
 - 8. Evaluation of alternative care to determine if the Member would be sufficient to achieve treatment goals, including:
 - a. Home health care;
 - b. Long term care (based upon the Member's benefit; see Policy 14F1, "Long Term Care (LTC) – Custodial Level" for more information);
 - c. Intermediate care (based upon the Member's benefit);
 - d. Adult day care (based upon the Member's benefit; see Policy 12H, "Community Based Adult Services (CBAS)" or child day care;
 - e. Family education and training; and

14. UTILIZATION MANAGEMENT

F. Long Term Care 2. Skilled Level

- f. Community networks and resources.
- I. Appropriately licensed staff must assist in the evaluation and placement of Members into LTC facilities including involvement in the development, management, and monitoring of Member treatment plans.
- J. The treatment plan is implemented, evaluated, and revised by the team of Providers and staff including, but not limited to, UM and/or CM staff, physicians, long term care Providers and staff, and IEHP or the Delegated IPA, as appropriate. The Member and family also are involved in the treatment plan implementation process to the extent necessary.
- K. The UM/CM staff, together with the interdisciplinary team of Providers and staff, guide the Member toward meeting the treatment plan goals that include transfer to a lower level of care when it is medically appropriate.
- L. UM/CM staff assists in the discharge planning process and the transfer and follow-up of the Member to the next level of care.
- M. Transfer to a board and care or home environment is initiated when it is determined that the Member is at a “custodial” level of care and can be safely managed at a lower level of care (based upon the Member’s benefit).
- N. Authorization will be given for bed hold upon request by the skilled nursing facility.
 - 1. The bed hold will be authorized for up to seven (7) calendar days.
 - 2. A separate authorization will be issued for a seven (7) calendar day bed hold.
 - 3. If the Member does not return to the LTC facility who requested the hold in seven (7) calendar days, the bed hold will expire.
 - 4. The LTC facility must accept the Member back, if requested, in order to receive payment for the bed hold.
- O. Accommodation Codes will be authorized as follows:
 - 1. All accommodation codes require an authorization within the inpatient authorization.
 - 2. All accommodation codes are approved on a case-by-case basis after review of supporting clinical documentation.
 - 3. Accommodation code 560 does not apply to the use of alcohol and marijuana.
- P. Financial responsibility for IEHP DualChoice Members continues for up to one hundred (100) days per benefit period. IEHP or Delegated IPA will ensure that the Member is admitted to a contracted facility, as applicable. IEHP or Delegated IPA is responsible for notifying the IEHP DualChoice Member, assigned PCP, and LTC facility that the benefits expire after one hundred (100) days of inpatient care per benefit period, and again prior to the Member exceeding the one hundred (100) days benefit limit.
- Q. The Medical Director or physician designee reviews all medical necessity denials. All denial

14. UTILIZATION MANAGEMENT

F. Long Term Care 2. Skilled Level

decisions are made in writing to the PCP, attending physician, facility, and Member. The initial notification is made to the Provider within twenty-four (24) hours via phone or fax.

- R. The facility provides Practitioners and Members a written or electronic notification of the decision of non-coverage of further LTC skilled no later than two (2) calendar days prior to proposed termination of services.
1. The Notice of Medicare Non-Coverage (NOMNC) letter may be delivered earlier if the date that coverage will end is known.
 2. If the expected length of stay or service is two (2) days or less, the NOMNC letter must be given on admission.
 3. The NOMNC should not be used when it is determined that the Member's services should end based on the exhaustion of benefits (such as the one hundred (100) day long term care limit per benefit period). If the Provider is unable to personally deliver the NOMNC to a person legally acting on behalf of a Member, then the Provider should telephone the representative to advise him or her of the following:
 - a. The proposed termination of services; and
 - b. The Member's appeal rights must be explained and the name and telephone number of the Quality Improvement Organization (QIO) should be provided.
 - c. The date of the conversation with the Member's representative is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date.
 - d. When direct phone contact cannot be made, the notice is sent to the Member's representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt for the NOMNC letter.
 - e. The Delegate must issue the Detailed Explanation of Non-Coverage (DENC) to QIO no later than the date specified and the facility must issue a copy to the Member.
- S. On the 15th of each month, Delegated IPAs must notify IEHP of Members who are receiving skilled care as of the previous month or are estimated to require long term care greater than the one hundred (100) days LTC skilled limit per benefit period by faxing the Long Term Care (LTC) Data Sheet along with the face sheet to (909) 912-1044. (See Attachment, "Long Term Care (LTC) Data Sheet" in Section 14).

14. UTILIZATION MANAGEMENT

- F. Long Term Care
 - 2. Skilled Level
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REFERENCES:

- A. Coordinated Care Initiative (CCI) Three-Way Contract, Section 2.15, eff January 1st, 2018.
- B. Code of Federal Regulations, Title 42 §§422.624.

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14. UTILIZATION MANAGEMENT

G. Acute Admission and Concurrent Review

APPLIES TO:

- A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

- A. Delegated IPAs are responsible to perform inpatient utilization management activities as outlined in their contract.
- B. For those Delegated IPAs not delegated to perform inpatient utilization management activities, IEHP is responsible for inpatient concurrent review. The Delegated IPA is responsible for notifying IEHP utilization management (UM) staff of any facility admissions.
- C. Contracted and non-contracted facilities are required to notify IEHP or the Member's Delegated IPA via fax, phone or Electronic Data Interchange (EDI) submission of a Member's inpatient admission or as soon as the facilities deem the Member's need for inpatient admission.
- D. IEHP reviews all clinical documents received and responds within one (1) hour of receipt of clinical documentation. If supporting documentation is received timely and IEHP fails to respond within these timeframes, IEHP will approve the first day of admission for post-stabilization. All subsequent days are subject to review for medical necessity.
- E. IEHP requires contracted and non-contracted facilities to submit clinical documentation daily to validate inpatient admission and subsequent stays. IEHP has the authority to deny payment for the delivery of such necessary post-stabilization medical care or the continuation of the delivery of such care if clinical documentation is not received timely.
- F. Prior to any termination or non-coverage of services, the Provider of the service must provide valid delivery of the written notification to the Member and/or the Member's representative of the decision to terminate services. Valid delivery means that the Member and/or Member's representative must be able to understand the purpose and contents of the notice in order to sign for receipt of it.

PURPOSE:

- A. To ensure the appropriateness of inpatient admission, level of care, and length of stay (LOS) based upon medical necessity.

DEFINITION:

- A. Non-Contracted facilities – Facilities that do not have contracted agreements with IEHP.

PROCEDURES:

- A. IEHP or Delegated IPA is notified by the Hospital or long-term acute care (LTAC) facility's Case Management or Admitting Department of all inpatient admissions, including those

14. UTILIZATION MANAGEMENT

G. Acute Admission and Concurrent Review

planned and unplanned transitions. Admission review is performed within one (1) business day of knowledge of admission.

1. IEHP and its Delegated IPA's Inpatient UM department maintain a daily census in their medical management system to identify Members that have transitioned from one setting to another setting.
- B. Contracted and non-contracted facilities must notify IEHP upon the Member's admission to obtain authorization for inpatient stays. All clinical documentation must demonstrate the medical necessity of inpatient admission, based on nationally recognized clinical criteria and submitted to IEHP within twenty-four (24) hours of the Member's admission. If clinical documents are not received timely, the inpatient admission will be at risk for timely review and may potentially be denied.
- C. All continued stays will be authorized concurrently as clinical reviews are received. Contracted facilities can view their authorizations on the secure IEHP Provider portal, while non-contracted facilities will be verbally notified of their authorizations.
 1. Final authorization will be given once a discharge date and all discharge needs have been received from the facility, with the exception of when a tracking number may be necessary prior to the admission or transfer for services such as transfer to higher, LTAC, skilled nursing facility (SNF), or acute rehabilitation (AR).
- D. Concurrent review is performed daily for per diem contracts or based on clinical criteria for Medicare Severity Diagnosis Related Group (MS-DRG) contracts until discharge. Concurrent review can be performed either on-site by chart review or telephonically. Please refer to Policies 14J, "Long Term Care (LTC) – Custodial Level" and 14K, "Long Term Care (LTC) – Skilled Level" for review schedules specific to these levels of care.
- E. Reviews should include Physician communication and ongoing communication with other healthcare professionals involved in the Member's care, as necessary. Authorization decisions must be made within twenty-four (24) business hours of receipt of request.
- F. IEHP must receive all clinical documentation within three (3) business days from discharge date. If clinical documentation is not received timely, IEHP will issue a denial of payment to the facility due to lack of clinical documentation supporting medical necessity.
- G. All claims for Hospital days subsequent to the discharge will be reviewed retrospectively. Please see Policy 25E1, "Utilization Management Delegation and Monitoring" for more information.
- H. Nationally recognized clinical criteria and IEHP UM Subcommittee Approved Authorization Guidelines are utilized for justifying medically necessary services at the appropriate level of care (e.g. acute, sub-acute, skilled nursing, and home/community) and length of stay must be applied and documented in a consistent manner. The application of criteria takes into consideration individual factors such as age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment. Additionally, application of criteria takes into consideration whether services are available within the service area, benefit

14. UTILIZATION MANAGEMENT

G. Acute Admission and Concurrent Review

coverage, and other factors that may impact the ability to implement an individual Member's care plan.

- I. Member eligibility and benefits are verified to ensure appropriate authorization and management of services.
- J. Chronic, complex, high risk, high cost, re-admissions or catastrophic cases are referred for potential care management, transition of care (TOC) and/or disease management interventions. Cases are reviewed by the Medical Director or designee who may refer to the UM Subcommittee as deemed necessary.
- K. (For non-global risk Delegated IPAs only) Delegated IPAs that have accountability for inpatient utilization management must notify IEHP of Members with inpatient stay on day twenty (20) and weekly by completing and faxing the Acute Inpatient Data Sheet along with the face sheet (909) 477-8553 (See Attachment, "Acute Inpatient Data Sheet" in Section 14). Subsequent reviews must be sent to IEHP weekly until the Member is discharged.
- L. Board-certified physicians from appropriate specialty areas assist with determinations of medical appropriateness, as needed.
- M. IEHP or Delegated IPA UM or care management (CM) staff, as appropriate, is assigned to perform Hospital concurrent review and must document findings in the medical management system. If IEHP or the Delegated IPA Medical Director or physician designee denies the continued stay and the attending physician does not agree with the decision, either the attending physician or Member may initiate an expedited appeal. Following completion of the expedited review process, the admission is either authorized or denied. Care must not be discontinued until the treating Practitioner has been notified and the treating Practitioner has agreed upon a care plan. Please see Section 16, "Grievance and Appeal Resolution System" for more information.
- N. Facilities, including acute, rehabilitation, long term acute care and psychiatric, must notify Members who are inpatient about their Hospital discharge appeal rights. Facilities must issue the Important Message from Medicare (IM) within two (2) calendar days of admission, must obtain the signature of the beneficiary or his or her representative and provide a copy at that time to the Member/Member's representative.
 - 1. A follow up copy must be delivered no more than two (2) calendar days before the planned date of discharge.
 - 2. When discharge cannot be predicted in advance, the follow up copy may be delivered as late as the day of discharge giving the beneficiary at least four (4) hours to consider their right to request a Quality Improvement Organization (QIO) review.
 - 3. If delivery of the original IM is within two (2) calendar days of the date of discharge, no follow up notice is required.
 - 4. If the Member is not able to comprehend the contents of the notice, the notice must be delivered to and signed by an authorized representative for the Member.

14. UTILIZATION MANAGEMENT

G. Acute Admission and Concurrent Review

5. If the Member refuses to sign the notice, the notice is still valid as long as the Provider documents that the notice was given, but the Member refused to sign.
 6. The Detailed Notice of Discharge must be completed with all necessary information and delivered to the Member by the facility.
- O. The attending Physician is responsible for the Member's care while hospitalized and must perform the following functions:
1. Assess the Member's medical status upon admission, determine level of care and estimated length of stay, and document this information in the medical record;
 2. Verify that appropriate medical criteria were utilized for inpatient admission;
 3. Communicate the medical assessment to IEHP or Delegated IPA UM/CM staff either verbally or in writing; and
 4. Continue to document medical necessity in the medical record for the duration of the Member's Hospital stay.
- P. IEHP and its Delegated IPAs' UM/CM Staff are responsible for identifying and referring any potential quality incident (PQI) occurring in an inpatient or outpatient setting to IEHP's Quality Management (QM) Department. Indicators used for identification of PQI include the following:
1. Unexpected death (maternal/perioperative/neonatal);
 2. Unplanned return to the operating room;
 3. Anesthesia event (neurological impairment);
 4. Extended length of stay due to iatrogenic complications;
 5. Retained foreign object;
 6. Decubitus development;
 7. Nosocomial infection;
 8. Readmissions within thirty (30) days of discharge (same diagnosis);
 9. Serious Reportable Adverse Events (SRAEs), such as surgery on wrong patient, surgery on wrong body part, etc.; and
 10. Provider Preventable Conditions (PPC) and/or Health Care-Acquired Conditions (HCAC).
- Q. Focused reviews are conducted for known problem diagnoses, procedures, or Practitioners requiring guidance in managing the utilization of services.

14. UTILIZATION MANAGEMENT

G. Acute Admission and Concurrent Review

REFERENCES:

- A. Health and Safety Code §1317.4a.
- B. Part C& D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Section 100, Provider Notices in Hospital, SNF, HHA, CORF Settings (Part C Only).
- C. Coordinated Care Initiative (CCI) Three-Way Contract, Section 2.10 eff January 1st, 2018.

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14. UTILIZATION MANAGEMENT

H. Hospice Services

APPLIES TO:

- A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

- A. If a Member elects to receive the Medicare hospice benefit, the Enrollee may remain in IEHP DualChoice but will obtain the hospice service through their Medicare Fee-For-Service benefit.
- B. IEHP DualChoice and Providers of hospice services would be required to coordinate these services with the rest of the Member’s care.

PROCEDURE:

- A. Prior authorization from IEHP is not required for evaluation by a Medicare certified hospice provider.

REFERENCE:

- A. Coordinated Care Initiative (CCI) Three-Way Contract, Section 4.2, eff January 1st, 2018.

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14. UTILIZATION MANAGEMENT

I. Expedited Initial Organization Determinations

APPLIES TO:

- A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

- A. IEHP and its Delegates perform Expedited Initial Organization Determinations (EIOD) for service authorization requests where the Provider indicates or IEHP or the Delegate determines that following the standard timeframe for issuing a determination could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.
- B. The Member, applicable representative, or treating Practitioner may submit an oral or written request for an EIOD if:
1. The Member or Practitioner believes that waiting for a decision under the standard timeframe could place the Member's life, health, or ability to regain maximum function in serious jeopardy; and
 2. The Member believes IEHP should furnish directly or arrange for services to be provided (when the Member has not already received the services outside of IEHP).

DEFINITION:

- A. Delegate – For the purpose of this policy, this is defined as a medical group, Delegated IPA, or any contracted organization delegated to provide utilization management services.

PROCEDURES:

- A. EIODs may not be requested for cases in which the only issue involves claims payment for services the Member has already received.
- B. IEHP and its Delegates must render a decision as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after IEHP or the Delegate receives the request for an EIOD.
- C. An EIOD is automatically provided when the request is made or supported by a Practitioner. The Practitioner must indicate, either orally or in writing, that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.
- D. If clinical information is needed from a non-contracted practitioner, IEHP or the Delegate will request this information within twenty-four (24) hours of the initial request for an EIOD. Non-contracted practitioners must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist in meeting the required

14. UTILIZATION MANAGEMENT

I. Expedited Initial Organization Determinations

timeframe. Regardless of whether IEHP or the Delegate requests clinical information from non-contracted practitioners, IEHP and Delegates are still responsible for meeting the same timeframe and notification requirements for EIODs.

- E. If it is determined that the Member's condition does not warrant an expedited determination, the Member will be verbally notified within seventy-two (72) hours of receipt of the request (includes weekends and holidays) followed by written notification within three (3) calendar days of the verbal notification. The request will automatically be processed for a determination within the standard timeframe of fourteen (14) calendar days from the day the request was received for an EIOD. The Expedited Criteria Not Met notice must:
1. Explain that the request will be processed using the fourteen (14) calendar day timeframe for standard determinations;
 2. Inform the Member of the right to file an expedited grievance if he or she disagrees with the decision to not expedite the determination, give instructions for filing an expedited grievance, give the expedited grievance process timeframe, and an explanation of the criteria for expedited reviews;
 3. Inform the Member of the right to resubmit a request for an EIOD if the Member gets any Practitioner's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function. The request will be expedited automatically; and
 4. Provide instructions about the expedited grievance process and its timeframes.
- F. If the request is approved for an EIOD, the determination must be made in accordance with the following requirements:
1. Whether the decision is to approve, modify, or deny, the Member and Practitioner must be notified of the decision within seventy-two (72) hours of receipt of the request;
 2. If the initial verbal notification to the Member of the expedited determination was successful, then written notification to the Member must occur within three (3) calendar days of the verbal notification. All attempts of verbal communication with Members must be documented with the time, date, and initials of IEHP or Delegate's staff making the call; and
 3. If verbal notification is unsuccessful, written notification is given for a modification or denial determination, the Member and Practitioner must receive the notification within seventy-two (72) hours of receipt of the EIOD request.
- G. Written communication regarding a modification or denial must be written in a manner that is understandable and sufficient in detail so that the Member and Practitioner can

14. UTILIZATION MANAGEMENT

I. Expedited Initial Organization Determinations

understand the rationale for the decision. The Integrated Denial Notice (IDN), also known as Notice of Denial of Medical Coverage, letter must include:

1. The specific reason for the denial that takes into account the Member's presenting medical condition, disabilities, and special language requirements, if any;
 2. The determination is based upon Medicare Coverage Guidelines;
 3. Information regarding the Member's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the Member's behalf;
 4. A description of both the standard and expedited reconsideration processes that include conditions for obtaining an expedited reconsideration, and the other elements of the appeals process; and
 5. The Member's right to submit additional evidence in writing or in person.
- H. An extension of no more than fourteen (14) calendar days may be allowed to perform the review under the following circumstances:
1. There is justification for additional information (e.g., allowing for additional diagnostic procedures or specialty consultations) and there is documentation on how this delay is in the interest of the Member.
 2. The Member or Practitioner requests an extension of time to provide IEHP with additional information.
 3. The Practitioner requesting the EIOD is not contracted and the clinical information necessary to make the determination is not submitted within seventy-two (72) hours. An attempt to contact the non-contracted provider will be made within twenty-four (24) hours of receipt.
- I. Extensions must not be used to pend organization determinations while waiting for medical records from contracted Providers.
- J. The Member will be notified in writing of the reason for the delay, utilizing the Extension Needed for Additional Information – Expedited and Standard Initial Determination letter, and informed of the right to file an expedited grievance (oral or written) if he or she disagrees with the decision for an extension. The written notification for the extension will include the clinical information needed or the test or examination required.
- K. Timeframe and notification requirements for all EIOD requests will be identified and reviewed on the Denial and Approval universe submitted by IPAs on a monthly basis as outlined in Policy 25E2, "Utilization Management - Reporting Requirements" and Attachment, "IEHP Universe Standard Auth MSSAR Template" in Section 25.

14. UTILIZATION MANAGEMENT

I. Expedited Initial Organization Determinations

REFERENCES:

- A. Coordinated Care Initiative (CCI) Three-Way Contract, Section 2.11 eff January 1st, 2018.
- B. Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/Coverage, Determinations, and Appeals Guidance”.

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14. UTILIZATION MANAGEMENT

Attachments

| <u>DESCRIPTION</u> | <u>POLICY CROSS REFERENCE</u> |
|---|-----------------------------------|
| Acute Inpatient Data Sheet | 14G |
| Health Plan Referral Form for Out-of-Network and Special Services | 25E1 |
| Long Term Care (LTC) Data Sheet | 14F2 |
| Long Term Care (LTC) Follow-up Review Form | 14F2 |
| Long Term Care (LTC) Initial Review Form | 14F2 |
| PCP Referral Tracking Log | 14A1, 14A2, 14B |
| Specialty Office Service Auth Sets Grid | 14D |
| Standing Referral / Extended Access Referral to Specialty Care | 14A3 |
| UM Timeliness Standards – IEHP DualChoice | 14D, 14E, 25E1 |



Inland Empire Health Plan
Acute Inpatient Data Sheet
 (20 Day Stays and Greater)

IPA Name _____ **Date Submitted** _____
Submitted By _____ **Contact Number** _____

Please fax reviews on day 20 and weekly thereafter to (909) 477-8553.

| Member Name | Member ID | Age / Gender | Facility Name | Admission / Enrollment Date | Attending Physician | Clinical Summary (e.g. Presenting DX, Co-morbidities/complications resulting in extended stay) | Discharge Plan | If out-of-area/network, explain? *See Legend | Comments |
|-------------|-----------|--------------|---------------|-----------------------------|---------------------|--|----------------|--|----------|
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***Legend:**

- CC = Care Coordination
- COC = Continuity of Care
- HLOC = Higher Level of Care
- ED = Emergency Department Admit
- NBAN = No Bed Available in Network



**HEALTH PLAN REFERRAL FORM
OUT-OF-NETWORK PROVIDERS/SPECIAL SERVICES**

This form is for services requiring health plan review.

1. Referrals

| | |
|---|---|
| DATE: _____ <input type="checkbox"/> /EXPEDITED - Decision w/in 72 hours <input type="checkbox"/> ROUTINE <input type="checkbox"/> PATIENT REQUESTED <input type="checkbox"/> RETRO <input type="checkbox"/> CPO Services <input type="checkbox"/> CBAS | (TO BE COMPLETED BY IEHP) AUTH/TRACKING NUMBER: _____ AUTH/EXPIRATION DATE: _____ |
|---|---|

2. GENERAL INFORMATION

| | | | |
|-------------------------------|--|---|--|
| Member Name (please print) | | DOB | ID # |
| Plan (select one) | <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Healthy Families | <input type="checkbox"/> Non-State Programs <input type="checkbox"/> | <input type="checkbox"/> Open Access <input type="checkbox"/> Medicare |
| Address | City | Zip | Phone |
| Diagnosis (Required) <u>z</u> | | | Diagnosis Code (REQUIRED) |

Clinical justification for referral and description of procedure requested if any (required) (attach clinical information). When requesting services out-of-network, please provide documentation of failed attempts at in-network providers/facilities.

| | | | |
|---|------------|-------|-------|
| Referred to (must refer to a specialist within network) | Specialty: | NPI#: | Phone |
| Address: | City: | Zip | Fax |
| Referring Provider (please print) | Phone | Fax | |
| Address | City | Zip | |
| Referring Provider Signature (REQUIRED) | NPI# | Date | |

3. SERVICE REQUESTED

| | | | | | |
|--|----------------------------------|-------------------------------------|------------------------------------|--------------------------------------|--------------------------------|
| Service Requested (check one) | <input type="checkbox"/> Consult | <input type="checkbox"/> Follow-up | <input type="checkbox"/> DME | <input type="checkbox"/> Home Health | <input type="checkbox"/> Other |
| Service Location/Facility: | <input type="checkbox"/> Office | <input type="checkbox"/> Outpatient | <input type="checkbox"/> Inpatient | | |
| Procedure Requested (Submit supportive documentation with the claim to justify the Evaluation and Management (E & M) code if this service will occur the same day as the procedure.) | | | | CPT Code (REQUIRED) | |
| Facility Address | Phone | Fax | | | |

4. COMPLETED BY IEHP

| | | | | |
|---|---------------------------------------|---|-----------------------------------|--------------------------------|
| Date Additional Information Required: | Date Additional Information Received: | <input type="checkbox"/> Approved | <input type="checkbox"/> Modified | <input type="checkbox"/> Other |
| Assigned IPA: | | | | |
| Medical Reviewer Comments | | | | |
| Medical Reviewer Signature (Circle Title: MD, DO, RN, LVN, Coordinator) | Date | Criteria utilized in making this decision is available upon request by calling IEHP (866) 725-4347. | | |

UPON ACCEPTANCE OF REFERRAL AND TREATMENT OF THE MEMBER, THE PHYSICIAN/PROVIDER AGREES TO ACCEPT IEHP CONTRACTED RATES. This referral/authorization verifies medical necessity only. Payments for services are dependent upon the Member's eligibility at the time services are rendered.

FAX COMPLETED REFERRAL FORMS TO (909) 890-5751



HEALTH PLAN REFERRAL FORM
OUT-OF-NETWORK PROVIDERS/SPECIAL SERVICES

NOTICE: This facsimile contains confidential information that is being transmitted to and is intended only for use of the recipient named above. Reading, disclosure, discussion, dissemination, distribution, or copying of this information by anyone other than the named recipient or his or her employees or agents is strictly prohibited. If you have received this facsimile in error, please immediately destroy it and notify us by telephone at **(866) 725-4347**.



Inland Empire Health Plan

**INLAND EMPIRE HEALTH PLAN
LONG-TERM CARE (LTC) DATA SHEET**

IPA Name: _____

Date Submitted: _____

Report for Month of: _____

Submitted by: _____

| Member Name | Member ID | Facility Name | Attending Physician | Reason for Admit (deconditioning, IVABX, wd care, etc.) | Admission/ Enrollment Date | Last Cover Date (LCD) | Total SNF Days (Include past & present days) | Prior Residence *See Legend: | Is Member at risk for custodial care? Why? | Member Remains Skilled or Custodial |
|-------------|-----------|---------------|---------------------|---|----------------------------|-----------------------|--|------------------------------|--|-------------------------------------|
| | | | | | | | | | | |
| | | | | | | | | | | |
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***Legend:**
 BC = Board & Care
 GH = Group Home
 LA = Lives Alone
 AL = Assisted Living
 HL = Homeless
 SNF = Skilled Nursing Facility



LTC FOLLOW-UP REVIEW

Please fax completed form to your facility's assigned IEHP Nurse.

All questions contained in this questionnaire are strictly **confidential** and will become part of the Member's medical record.

| | | | | | | | | |
|--|--|------------------------------------|---|--|---|---|-----------------------------------|-------------------------------------|
| Facility: | | | | | | | | |
| Name <i>(Last, First, M.I.):</i> | | DOB: | | Reference # | | ID # | | |
| Activity Level: | | | | Height: | | Weight: | | |
| DCP: | <input type="checkbox"/> LTC | <input type="checkbox"/> B&C | <input type="checkbox"/> Home | <input type="checkbox"/> Home with HH | <input type="checkbox"/> Home with CBAS | <input type="checkbox"/> Home with IHSS/hr/mo | #hrs/month: | |
| Cognitive Status Alert/Oriented: | <input type="checkbox"/> x1 | <input type="checkbox"/> x2 | <input type="checkbox"/> x3 | <input type="checkbox"/> x4 | | | | |
| Criteria Met for Continued Stay: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, please describe deficit: | | | | | |
| Behavioral Change: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, please describe: | | | | | |
| Dietary Change: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, please describe: | | | | | |
| Medical Change: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, please describe: | | | | | |
| Medication Change: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, please describe: | | | | | |
| Skin Condition Change: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, please describe: | | | | | |
| Any Falls Since Last Review: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, please describe: | | | | | |
| Does SNF Facility Provide Transportation?: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If no, please indicate needs: | | <input type="checkbox"/> O ₂ | <input type="checkbox"/> Cane | <input type="checkbox"/> Gurney | <input type="checkbox"/> Wheelchair |
| CONTINUED CARE NEEDS | | | | | | | | |
| Resident Care Needs <i>(Check all conditions that apply):</i> | | | | | | | | |
| <input type="checkbox"/> Chemo | <input type="checkbox"/> Eloper/ Wanderer | <input type="checkbox"/> Ileostomy | <input type="checkbox"/> O ₂ | <input type="checkbox"/> Trach | Wounds | <input type="checkbox"/> Surgical | <input type="checkbox"/> Pressure | |
| <input type="checkbox"/> Colostomy | <input type="checkbox"/> Foley Cath | <input type="checkbox"/> Isolation | <input type="checkbox"/> Smoker | <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> Arterial | #: _____ | |
| <input type="checkbox"/> Coma | <input type="checkbox"/> G/J Tube | <input type="checkbox"/> NG Tube | <input type="checkbox"/> Radiation | <input type="checkbox"/> Suctioning/ Frequency: _____ | | <input type="checkbox"/> Venous | Stage(s): _____ | |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> HHN | <input type="checkbox"/> NPO | <input type="checkbox"/> TPN | | | <input type="checkbox"/> Foot Wounds | | |
| Activity Level | Bed Mobility | <input type="checkbox"/> Max | <input type="checkbox"/> Mod | <input type="checkbox"/> Min | <input type="checkbox"/> Assist | <input type="checkbox"/> Independent | | |
| | Supine to Sit | <input type="checkbox"/> Max | <input type="checkbox"/> Mod | <input type="checkbox"/> Min | <input type="checkbox"/> Assist | <input type="checkbox"/> Independent | | |
| | Sit to Supine | <input type="checkbox"/> Max | <input type="checkbox"/> Mod | <input type="checkbox"/> Min | <input type="checkbox"/> Assist | <input type="checkbox"/> Independent | | |
| Indicate all appropriate assistive device(s) Member uses: | | | | <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Cane | <input type="checkbox"/> Walker | <input type="checkbox"/> Other | |
| • Gait Distance | x _____ | ft. | | | | | | |
| • Wheelchair Mobility | x _____ | ft. | <input type="checkbox"/> Min | <input type="checkbox"/> Mod | <input type="checkbox"/> Max Assist | <input type="checkbox"/> Independent | | |
| • Safety/Balance | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | | | | | |
| • Endurance | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | | | | | |
| • Dressing Upper Body | <input type="checkbox"/> Min | <input type="checkbox"/> Mod | <input type="checkbox"/> Max Assist | <input type="checkbox"/> Independent | | | | |
| • Dressing Lower Body | <input type="checkbox"/> Min | <input type="checkbox"/> Mod | <input type="checkbox"/> Max Assist | <input type="checkbox"/> Independent | | | | |
| • Toileting | <input type="checkbox"/> Min | <input type="checkbox"/> Mod | <input type="checkbox"/> Max Assist | <input type="checkbox"/> Independent | | | | |
| • Bathing | <input type="checkbox"/> Min | <input type="checkbox"/> Mod | <input type="checkbox"/> Max Assist | <input type="checkbox"/> Independent | | | | |
| • Personal Hygiene | <input type="checkbox"/> Min | <input type="checkbox"/> Mod | <input type="checkbox"/> Max Assist | <input type="checkbox"/> Independent | | | | |
| Treatment Goals Set: | | | | | | | | |
| Treatment Goals Met: | | | | | | | | |
| Comments/Other (e.g. Specialty Consultation): | | | | | | | | |
| | | | | | | | | |
| Updates to Discharge Plan: | | | | | | | | |
| | | | | | | | | |

Date of Review

Nurse Reviewer Printed Name

Nurse Reviewer Signature

Contact Phone Number



SNF INITIAL REVIEW

Please fax completed form to your facility's assigned IEHP Nurse.

All questions contained in this questionnaire are strictly **confidential** and will become part of the Member's medical record.

| | | | |
|---|---|--|------------------------|
| Name (Last, First, M.I.): | DOB: | Auth # | Admission Date: |
| Facility: | Attending: | | |
| Admit Dx: | Height: | | Weight: |
| Co-Morbidities: | | | |
| Admit Level of Care: | <input type="checkbox"/> Sub acute <input type="checkbox"/> Level 4 <input type="checkbox"/> Level 3 <input type="checkbox"/> Level 2 <input type="checkbox"/> Level 1 <input type="checkbox"/> Custodial | | |
| Justification for Level: | | | |
| DCP: | <input type="checkbox"/> LTC <input type="checkbox"/> B&C <input type="checkbox"/> Home <input type="checkbox"/> Home with HH <input type="checkbox"/> Home with CBAS <input type="checkbox"/> Home with IHSS/hr/mo #hrs/month: _____ | | |
| Current Barriers to DCP: | | | |
| Treatment Goals: | | | |
| Prior Living Conditions: | | | |
| Prior Level of Function: | | | |
| Does Member have social or family support? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____ | | | |
| Does Member own DME? <input type="checkbox"/> Yes <input type="checkbox"/> No Type? _____ | | | |
| Does Member have income? <input type="checkbox"/> Yes <input type="checkbox"/> No How much per month? _____ | | | |
| Does Member Have an Advance Directive or Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No | | DPOA: | Phone Number: |
| Does SNF Facility Provide Transportation? | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other: _____ | |
| Indicate Transportation Needs: | | | |
| <input type="checkbox"/> O ₂ <input type="checkbox"/> Cane <input type="checkbox"/> Gurney <input type="checkbox"/> Wheelchair | | | |
| Does Member have the potential to go back home when ready for discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Why? _____ | | | |

PATIENT SUPPORT/CAREGIVER

| | |
|----------------------------------|----------------------|
| Name (Last, First, M.I.): | Relationship: |
| Address: | Email: |
| Party to Sign Contract: | |
| Home Number: | Cell Number: |
| | Work Number: |

PERSONAL SAFETY & ACTIVITY LEVEL

Resident Care Needs (Check all conditions that apply):

Dietary Requirements/Restrictions:

| | | | | | | | |
|--|--|------------------------------------|---|--|--------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Chemo | <input type="checkbox"/> Eloper/Wanderer | <input type="checkbox"/> Ileostomy | <input type="checkbox"/> O ₂ | <input type="checkbox"/> Trach | Wounds | <input type="checkbox"/> Surgical | <input type="checkbox"/> Pressure |
| <input type="checkbox"/> Colostomy | <input type="checkbox"/> Foley Cath | <input type="checkbox"/> Isolation | <input type="checkbox"/> Smoker | <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> Arterial | #: _____ |
| <input type="checkbox"/> Coma | <input type="checkbox"/> G/J Tube | <input type="checkbox"/> NG Tube | <input type="checkbox"/> Radiation | <input type="checkbox"/> Suctioning/Frequency: _____ | | <input type="checkbox"/> Venous | Stage(s): _____ |
| <input type="checkbox"/> Dialysis/Days | <input type="checkbox"/> HHN | <input type="checkbox"/> NPO | <input type="checkbox"/> TPN | | | <input type="checkbox"/> Foot Wounds | |

| | | | | | |
|------------------------|---|--------------------------------------|-------------------------------------|----------------------------------|---------------------------------------|
| Personal Safety | Does Member have stairs at home? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Many: | |
| | Does Member experience frequent falls? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| | Does Member have vision or hearing loss? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Glasses | <input type="checkbox"/> Hearing Aids |
| | Indicate all appropriate assistive device(s) Member uses: | <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Cane | <input type="checkbox"/> Walker | <input type="checkbox"/> Other |
| | • Ambulation x ft. | <input type="checkbox"/> Independent | <input type="checkbox"/> Max Assist | <input type="checkbox"/> Mod | <input type="checkbox"/> Min |
| | • Safety/Balance | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | |

Prior Level of Functioning:

Current Level of Functioning:

Discharge Plan:

ADMISSION PACKET CHECKLIST (PLEASE SEND WITH ALL NEW)

| | | | |
|---|--|-------------------------------------|--|
| Facesheet | <input type="checkbox"/> Yes <input type="checkbox"/> No | H & P | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Physician Orders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Wound Notes (If applicable) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| IFT (Inter-facility transfer form) | <input type="checkbox"/> Yes <input type="checkbox"/> No | SNF Initial | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| MC171 (Custodial) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Therapy Evaluation (Skilled) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| MDS (Custodial) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Assigned SNFST | <input type="checkbox"/> Yes <input type="checkbox"/> No |

MEDICATIONS (EXCLUDING PRN) PLEASE INCLUDE SEPARATE SHEET, IF NECESSARY.

| | | |
|--------------------------|------------------|-------------------------|
| Name the Drug(s): | Strength: | Frequency Taken: |
| | | |
| | | |

Date of Review

Nurse Reviewer Printed Name

Nurse Reviewer Signature

Contact Phone Number



PCP Referral Tracking Log

| Date Referral Sent to IPA | Member Name & Date of Birth | Acuity of Referral* | Reason for Referral/Dx | Service or Activity Requested | Date Auth. Received | Referral Decision** | Patient Notified | Date Appt or Service | Date Consult Report Rec'd or Outreach Effort |
|---------------------------|-----------------------------|---------------------|------------------------|-------------------------------|---------------------|---------------------|------------------|----------------------|--|
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* Acuity of Referral: Emergent, Urgent or Routine
 ** Decision: Approved, Modified or Denied



INLAND EMPIRE HEALTH PLAN

SPECIALTY OFFICE SERVICE AUTHORIZATION SETS

These procedures are to be performed in the office only. Specialty referral includes consult and up to two (2) follow-up visits unless otherwise noted and may include:

| Procedure | CPT Code |
|---|-----------------------------------|
| Allergy - Skin Testing for 80 or Fewer Tests | 95004 X up to 80 |
| CARD – EKG (Adult & Peds) | 93000 |
| CARD – Routine Stress Treadmill (Adult) | 93015 |
| CARD – Holter Monitor (Adult & Peds) | 93235 |
| CARD – Echocardiogram (Peds only) | 93303 or 93307 + 93320 + 93325 |
| DERM – Punch Biopsy | 11100 |
| DERM – Cryotherapy of Lesions | 17000, 17003, 17110 |
| DERM – Excision of Nail & Nail Matrix | 11750 |
| NEURO - EEG Standard | 95816 or 95819 |
| ENDO – Urinalysis | 81003 or 82948 |
| ENDO – Glucose/Blood | 82947 |
| ENDO – Fine Needle Aspiration of Thyroid | 10021-10022 |
| ENT – Tympanogram | 92567 |
| ENT – Pure Tone Audiogram | 92557, 92582 |
| ENT – Cerumen Removal | 69210 |
| ENT – Nasal Cauterization Treatment of Epistaxis (Anterior or Posterior) | 30901,30905 |
| ENT – Nasal Endoscopy | 31231, 31238 |
| ENT – Removal of Foreign Body Ear or Nose | 69200, 30300 |
| ENT – Streptococcus A Screen | 87880 |
| Gastroenterology – Flex Sigmoidoscopy | 45330 |
| GYN – Urine Pregnancy Test | 81025 |
| GYN – Depo-Provera | X6051 |
| GYN – Abnormal Pap Follow-Ups <i>and:</i> | 99213-99215 (X 3) |

P.O. Box 1800, Rancho Cucamonga, CA 91729-1800
Tel (909) 890-2000 Fax (909) 890-2003
Visit our web site at: www.iehp.org

A Public Entity

Attachment 14 - Specialty Office Service Auth Sets Grid

| Procedure | CPT Code |
|--|---|
| Colposcopy with Biopsy | 57452 or 57454-455, 57460 |
| Endometrial Biopsy | 58100, 58558 |
| LEEP | 57460 |
| | |
| Hematology - Bone Marrow Bx and/or Aspiration | 38221, 38220 |
| Hematology – Blood Smears | 86007-85008 |
| | |
| Nephrology – Urinalysis | 8100-81003 |
| | |
| Orthopedics – Total Fracture Care (Watch for CCS) X 6 mos. | By site of injury By date of service |
| Orthopedics – X-Rays, in office simple extremity | 73000-73140 |
| Orthopedics – Casting, Splints | |
| Orthopedics – DME (boot, shoe, crutches) | |
| Orthopedics – Joint aspiration | 20600-20615 |
| Orthopedics – Trigger point injections | |
| Injection of Tendon & Ligament | 20550-20553 |
| Injection of Bursa | 20600, 20605, 20610 |
| | |
| Podiatry – Matrixectomy | 11750 |
| Podiatry – Debridement of Nails | 11720-11721 |
| | |
| Pulmonary – Spirometry | 94010, 94060 |
| Pulmonary – Blood Gases | 82800-82810 |
| | |
| Radiology - Mammogram | 77057 |
| - Breast Ultrasound @ radiologist suggestion | 76645 |
| - Cone View | 77055 |
| | |
| Rheumatology – T.P Injection | 20552 |
| Rheumatology – Injection of Tendon & Ligament | 20550-20553 |
| Rheumatology – Joint Aspiration | 20600-20615 |
| | |
| Surgery – Breast Biopsy | 77031 |
| Surgery – I & D of Cutaneous Abscess | 10060-10061 |
| | |
| Urology – Urinalysis | 81000-81003 |
| Urology - Cystoscopy | 52000 |



IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan)

Standing Referral / Extended Access Referral to Specialty Care Request

Date of Request _____

IPA/MG _____

PCP _____

Phone # _____

Phone # _____

FAX _____

Requesting MD _____

Phone # _____

FAX _____

Other Insurance _____

Phone # _____

Member Name _____

DOB ___ / ___ / ___ M F Phone # _____

Address _____

City _____

State _____

ZIP _____

Member ID # _____

Referral To (Physician Name): _____

Type of Specialist: _____

Phone # _____

FAX _____

Diagnosis Primary _____

ICD 10 _____

Diagnosis Secondary _____

ICD 10 _____

Practitioner Treatment Plan (Complete or attach)

| # Visits/Period | Visits/3 Months | Visits/6 Months | Visits/9 Months | Visits/1 Year |
|--|-----------------|-----------------|-----------------|---------------|
| Time Requested (fill in number of visits) | | | | |

Briefly, describe what is anticipated on each visit:

When was the diagnosis first made? _____

How many times has the patient been seen by the Specialist in the past year? _____

Additional information regarding treatment plan may be requested from the Specialist if necessary. If so, decision will be made within three (3) business days of receipt of the information.

Authorization remains valid only if Member is eligible.

Payment is contingent upon the patient's eligibility at the time service is rendered.

**Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)**

| Type of Request | Decision | Notification Timeframes |
|---|---|--|
| <p>Standard Initial Organization Determination (Pre-Service) - If No Extension Requested or Needed</p> | <p>As soon as medically indicated, within a maximum of fourteen (14) calendar days after receipt of request.</p> | <p>As soon as medically indicated not to exceed fourteen (14) days after the receipt of the request. Please ensure there is time allotted to incorporate mailroom processes.</p> |
| <p>Standard Initial Organization Determination (Pre-Service) - If Extension Requested or Needed</p> | <p>May extend up to fourteen (14) calendar days.</p> <p>Extension is allowed <i>only</i> if the Member or Provider requests or the organization justifies that:</p> <ul style="list-style-type: none"> • The extension is in interest of the Member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny); • There is a need for additional information where: <ul style="list-style-type: none"> ○ There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and ○ Such outstanding information is reasonably expected to be received within fourteen (14) calendar days. <p>Note: Extensions <i>must not</i> be used to pend organization determinations while waiting for medical records from contracted providers.</p> | <ul style="list-style-type: none"> • Use the MA-Extension: Standard & Expedited to notify member and provider of an extension. • Give notice in writing within fourteen (14) calendar days of receipt of request. The extension notice must include: <ul style="list-style-type: none"> ○ The reasons for the delay; ○ The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. <p>Please ensure there is time allotted to incorporate mailroom processes</p> <p>Note: The Health Plan must respond to an expedited grievance within twenty-four (24) hours of receipt.</p> <p><u>Decision Notification After an Extension:</u></p> <ul style="list-style-type: none"> • Must occur no later than expiration of extension. Use the IDN also known as Notice of Denial of Medical Coverage template for written notification of denial decision. |
| <p>Expedited Initial Organization Determination - If Expedited Criteria are not met</p> | <p>Promptly decide whether to expedite – determine if:</p> <ol style="list-style-type: none"> 1) Applying the standard timeframe could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function, or 2) If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member’s request for an expedited decision. <p>If submitted as expedited but determined not to be expedited, then standard initial organization</p> | <p>If request is not deemed to be expedited, give the member prompt (within seventy-two (72) hours) oral notice of the denial of expedited status including the member’s rights followed by written notice within three (3) calendar days of the oral notice.</p> <ul style="list-style-type: none"> ▪ Use the MA Expedited Criteria Not Met template to provide written notice. The written notice must include: <ol style="list-style-type: none"> 1) Explain that the Health Plan will automatically transfer and process the request using the fourteen (14)-day timeframe for standard determinations; 2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization’s decision not to expedite the determination; |

**Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)**

| Type of Request | Decision | Notification Timeframes |
|---|---|---|
| | determination timeframe applies: <ul style="list-style-type: none"> ▪ Automatically transfer the request to the standard timeframe. ▪ The fourteen (14) day period begins with the day the request was received for an expedited determination. | 3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician’s support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member’s ability to regain maximum function, the request will be expedited automatically; and 4) Provide instructions about the expedited grievance process and its timeframes. |
| <p>Expedited Initial Organization Determination</p> <p>- If No Extension Requested or Needed</p> <p>(See footnote)¹</p> | <p>As soon as medically necessary, within seventy-two (72) hours after receipt of request (includes weekends & holidays).</p> | <p>Within seventy-two (72) hours after receipt of request.</p> <ul style="list-style-type: none"> ▪ Approvals <ul style="list-style-type: none"> – Oral or written notice must be given to member and provider within seventy-two (72) hours of receipt of request. – Document date and time oral notice is given. – If written notice only is given, it must be received by member and provider within seventy-two (72) hours of receipt of request. ▪ Denials <ul style="list-style-type: none"> – When oral notice is given, it must occur within seventy-two (72) hours of receipt of request and must be followed by written notice within three (3) calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be received by member and provider within seventy-two (72) hours of receipt of request. <p>Use Integrated Denial Notice (IDN) template for written notification of a denial decision.</p> <p>–</p> |
| <p>Expedited Initial Organization</p> | <p>May extend up to fourteen (14) calendar days.</p> | <ul style="list-style-type: none"> • Use the MA-Extension: Standard & Expedited template to notify member and provider of an |

¹ Note: Health Plans may have referral requirements that may impact timelines. When processing expedited requests, groups must factor in the time it may take to refer the request to the health plan in the total seventy-two (72) hours to ensure that expedited requests are handled timely.

**Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)**

| Type of Request | Decision | Notification Timeframes |
|--|---|--|
| <p>Determination - If Extension Requested or Needed</p> | <p>Extension is allowed <i>only</i> if Member or the Provider requests or the organization justifies that:</p> <ul style="list-style-type: none"> • The extension is in the interest of the Member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny); • There is a need for additional information where: <ul style="list-style-type: none"> ○ There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and ○ Such outstanding information is reasonably expected to be received within fourteen (14) calendar days. <p>Note: Extensions <i>must not</i> be used to pend organization determinations while waiting for medical records from contracted providers.</p> <p>When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within twenty-four (24) hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within twenty-four (24) hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request).</p> <p>Documentation of the attempt within twenty-four (24) hours does not replace the requirement to send the written Extension Notice within seventy-two (72) hours if requested information is not received timely.</p> | <p>extension.</p> <ul style="list-style-type: none"> • Give notice in writing, within seventy-two (72) hours of receipt of request. The extension notice must include: <ul style="list-style-type: none"> ○ The reasons for the delay; ○ The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. <p>Note: The Health Plan must respond to an expedited grievance within twenty-four (24) hours of receipt.</p> <p><u>Decision Notification After an Extension:</u></p> <ul style="list-style-type: none"> ▪ <u>Approvals</u> <ul style="list-style-type: none"> – Oral or written notice must be given to member and provider no later than upon expiration of extension. – Document date and time oral notice is given. – If written notice only is given, it must be received by member and provider no later than upon expiration of the extension. ▪ <u>Denials</u> <ul style="list-style-type: none"> – When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within three (3) calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be received by member and provider no later than upon expiration of extension. – Use Integrated Denial Notice (IDN) template for written notification of a denial decision. |

**Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)**

| Type of Request | Decision | Important Message from Medicare (IM) | Detailed Notice of Discharge (DND) |
|--|---|---|--|
| <p>Hospital Discharge Appeal Notices (Concurrent)</p> | <p>Attending physician must concur with discharge decision from inpatient hospital to any other level of care or care setting. Continue coverage of inpatient care until physician concurrence obtained.</p> <p>Hospitals are responsible for valid delivery of the revised Important Message from Medicare (IM):</p> <ol style="list-style-type: none"> 1) within two (2) calendar days of admission to a hospital inpatient setting. 2) not more than two (2) calendar days prior to discharge from a hospital inpatient setting. <p>Health Plans or delegates are responsible for delivery of the Detailed Notice of Discharge (DND) when a member appeals a discharge decision. DND must be delivered as soon as possible but no later than noon of the day after notification by the QIO (Quality Improvement Organization).</p> | <p>Hospitals must issue the IM within two (2) calendar days of admission, obtain the signature of the member or representative and provide a copy of the IM at that time.</p> <p>Hospitals must issue a follow up IM not more than two (2) calendar days prior to discharge from an inpatient hospital.</p> <ul style="list-style-type: none"> ▪ NOTE: Follow up copy of IM is not required: <ul style="list-style-type: none"> ▪ If initial delivery and signing of the IM took place within two (2) calendar days of discharge. ▪ When member is being transferred from inpatient to inpatient hospital setting. ▪ For exhaustion of Part A days, when applicable. <p>If IM is given on day of discharge due to unexpected physician order for discharge, member must be given adequate time (at least several hours) to consider their right to request a QIO review.</p> | <p>Upon notification by the QIO that a member or representative has requested an appeal, the Health Plan or delegate must issue the DND to both the member and QIO as soon as possible but no later than noon of the day after notification by the QIO.</p> <p>The DND must include:</p> <ul style="list-style-type: none"> ▪ A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered. ▪ A description of any applicable Medicare coverage rules, instructions, or other Medicare policy, including information about how the member may obtain a copy of the Medicare policy from the MA organization. ▪ Any applicable Medicare health plan policy, contract provision, or rationale upon which the discharge determination was based. ▪ Facts specific to the member and relevant to the coverage determination sufficient to advise the member of the applicability of the |

**Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)**

| Type of Request | Decision | Important Message from Medicare (IM) | Detailed Notice of Discharge (DND) |
|-----------------|----------|---|--|
| | | | coverage rule or policy to the member’s case. <ul style="list-style-type: none"> ▪ Any other information required by CMS. |

| Type of Request | Decision | Notice of Medicare Non-Coverage (NOMNC) Notification | Detailed Explanation of Non-Coverage (DENC) Notification |
|--|--|---|--|
| <p>Termination of Provider Services:</p> <ul style="list-style-type: none"> ▪ Skilled Nursing Facility (SNF) ▪ Home Health Agency (HHA) ▪ Comprehensive Outpatient Rehabilitation Facility (CORF) <p>NOTE: This process does not apply to SNF Exhaustion of Benefits (100 day limit).</p> | <p>The Health Plan or delegate is responsible for making the decision to end services no later than two (2) calendar days or two (2) visits before coverage ends:</p> <ul style="list-style-type: none"> ▪ Discharge from SNF, HHA or CORF services <p>OR</p> <ul style="list-style-type: none"> ▪ A determination that such services are no longer medically necessary | <p>The SNF, HHA or CORF is responsible for delivery of the NOMNC to the member or authorized representative</p> <ul style="list-style-type: none"> ▪ The NOMNC must be delivered no later than two (2) calendar days or two (2) visits prior to the proposed termination of services and must include: member name, delivery date, date that coverage of services ends, and QIO contact information. ▪ The NOMNC may be delivered earlier if the date that coverage will end is known. ▪ If expected length of stay or service is two (2) days or less, give notice on admission. <p>Note: Check with Health Plan or delegate for delegated responsibility, as a Health Plan or delegate may choose to deliver the NOMNC instead of the provider.</p> | <p>Upon notification by the Quality Improvement Organization (QIO) that a member or authorized representative has requested an appeal:</p> <ul style="list-style-type: none"> ▪ The Health Plan or delegate must issue the DENC to both the QIO and member no later than close of business of the day the QIO notifies the Health Plan of the appeal. |