14. UTILIZATION MANAGEMENT

A. Utilization Management Delegation and Monitoring

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP is responsible for the development, implementation, and distribution of standards for Utilization Management (UM) processes and activities to contracted entities delegated to perform UM activities.

1. Delegates are responsible for meeting IEHP UM standards.

2. Delegates are responsible for implementing a process to track open and unused referrals as stipulated in their contract.

B. IEHP is responsible for maintaining a monitoring system for UM Program oversight.

C. The IEHP Delegation Oversight is responsible for performing an evaluation of UM Program objectives and progress on an annual basis with modifications, as directed by the Delegation Oversight Committee and IEHP Governing Board.

D. IEHP delegates all or partial UM activities to contracted entities that meet IEHP UM standards with the exception of referrals for foster children in the Open Access program, vision services, and referrals for behavioral health.

E. All Delegates must have a UM Plan, UM Policies and Procedures, and perform UM activities in a manner that meets IEHP, National Committee for Quality Assurance (NCQA), Department of Health Care Services (DHCS), and Department of Managed Health Care (DMHC) standards.

F. Practitioners and Delegate employees/staff who make utilization-related decisions are responsible for identifying barriers to care and instances of under/over utilization of services and assisting with appropriate use of services.

G. Members are not discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, medical history, claims history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source payment.

H. Delegates must have a Second Opinion process in place for Members requesting second opinions and submit a monthly log to IEHP (See Attachment, “Second Opinion Tracking Log” in Section 14).

I. Provider or Member appeals of UM decisions are handled through the IEHP Provider or Member grievance and appeals process. Please refer to Section 16, “Grievance Resolution System” for more information on Provider and Member grievances.

J. IEHP maintains Benefit Manuals for each product line, which outlines covered and non-
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covered services, procedures, and medical equipment.

K. IEHP’s UM staff and physicians are available to respond to Provider inquiries regarding authorization requests, status and clinical decisions and processes, Monday through Friday, from the hours 8:00 AM to 5:00 PM.

**DEFINITION:**

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

**PROCEDURES:**

A. **UM Standards:** IEHP is responsible for defining overall standards for UM activities performed by its Delegates. These standards represent the minimum performance level acceptable to IEHP for its Delegates; however, Delegates can choose to exceed any specific standard.

B. **Criteria:** Entities delegated to perform UM must use nationally recognized clinical criteria when making decisions related to medical care. Criteria sets approved by IEHP include IEHP UM Subcommittee Approved Authorization Guidelines, Medi-Cal Provider Manual, Title 22, American Medical Associations Current Procedural Terminology Manual, Milliman Care Guidelines, InterQual, and Apollo Managed Care Guidelines/Medical Review Criteria. IEHP may distribute additional criteria following approval by the IEHP QM Committee.

1. **Development:** Criteria or guidelines that are developed IEHP and used to determine whether to authorize, partially approve (modify), or deny health care services are developed with involvement from actively practicing health care practitioners. The criteria or guidelines must be consistent with sound clinical principles and processes and must be evaluated, and updated if necessary, at least annually.

2. **Application:** Delegates are required to apply criteria in a consistent and appropriate manner based on available medical information and the needs of individual Members. Delegates should ensure consistent application of UM Criteria by following this specific order as the Delegate is licensed to use:

   a. Check the Benefit/Guidelines for the Member’s line of business (Medi-Cal Provider Manual).

   b. Check if there is an approved IEHP UM Subcommittee guideline to reference and note the most current adopted date.

   c. Check evidence based clinical criteria such, as Milliman Care or InterQual Guidelines.

   d. Check Apollo Medical Review Criteria.
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When applying criteria, individual factors such as, age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment, when applicable, are taken into consideration. Additionally, criteria applied takes into consideration the issues of whether services are available within the service area, benefit coverage, and other factors that may impact the ability to implement an individual Member’s care plan. The organization also considers characteristics of the local delivery system available for specific patients, such as:

a. Availability of skilled nursing facilities, subacute care facilities or home care in the organization’s service area to support the patient after hospital discharge;

b. Coverage of benefits for skilled nursing facilities, subacute care facilities, home care where needed, or community based services; and

c. Local in network hospitals’ ability to provide all recommended services within the estimated length of stay.

3. Annual Review and Adoption of Criteria: Members of the UM Subcommittee and practitioners in the appropriate specialty, review clinical criteria annually and update as necessary. New criteria that become available prior to the annual evaluation are reviewed by IEHP’s Chief Medical Officer (CMO) and Medical Director and are presented to the IEHP UM Subcommittee for discussion, research, and refinement. Once IEHP’s UM Subcommittee has approved the criteria and updates, the information is disseminated to Providers via letter, website, email, or site visits.

4. Process for Obtaining Criteria: Delegates must disclose to network practitioners, Members, or the public, upon request, the clinical guidelines or criteria used for determining health care services specific to the procedure or condition requested. The Delegate may distribute the guidelines and any revision through the following methods:

a. In writing by mail, fax, or e-mail; or

b. On its website, if it notifies practitioners that information is available on line.

The Notice of Action Taken letter must state the address, toll free phone number and /or TTY/TDD number for obtaining the utilization criteria or benefits provision used in the decision. The following notice must accompany every disclosure of information: “The materials provided to you are guidelines used by the plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your Health Plan” (See Attachment, “Response to Request for UM Criteria” in Section 14). The Delegate must maintain a log of all
requests for criteria (See Attachment, “Request for UM Criteria Log” in Section 14).

5. **Annual Assessment of Consistency of UM Decisions (Inter-rater Reliability):** IEHP provides oversight of delegated UM activities by monitoring, reviewing, and measuring the denial and referral process on an on-going basis and by performing audits. Delegates are responsible for evaluating, at least annually, the consistency with which all appropriate practitioners included in utilization review apply appropriate criteria for decision-making. The sample assessed must be statistically valid, or the delegate may use one (1) of the following three (3) auditing methods (5 percent or 50 of its UM determination files, whichever is less, NCQA 8/30 methodology, or 10 hypothetical cases).

6. **Behavioral Health (BH) Triage and Referral:** For Medi-Cal, Members will be “screened” for specialty mental health by the Behavioral Health Unit. Members who are severe will be referred to their respective county of residence for county specialty mental health services. Members who are mild/moderate will be referred to an in-network IEHP Behavioral Health Provider. IEHP is responsible for mild to moderate behavioral health services. IEHP’s Behavioral Health unit can assist Members desiring to self-refer and/or with accessing behavioral health services as needed. IEHP Behavioral Health unit is responsible for ensuring triage and referral decisions are made according to protocols that define the level of urgency and appropriate setting of care. Triage and referral protocols utilized must be based on sound clinical evidence and currently accepted practices for behavioral health care service delivery. Please refer to Policy 12.K.1, “Behavioral Health Services,” for more information.

a. **The protocols address the urgency of the** Member’s clinical circumstances and define the appropriate care settings and treatment resources that are to be used for behavioral health and substance abuse cases.

b. Triage and referral staff members must utilize protocols and guidelines that are up-to-date and the staff must be provided appropriate education and training regarding their use.

c. Protocols used by staff are reviewed and/or revised annually.

C. **Delegate UM Structure:**

1. Delegated entities must have the following UM structure and processes in place:

a. **UM Program Description, policies, procedures, and UM activities that meet IEHP and NCQA standards.** These policies and procedures must ensure that decisions based on the medical necessity of proposed health care services are consistent with sound clinical principles and processes. These policies and procedures must address the Delegate’s responsibility for continuity and coordination of care for Members with medical and/or
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behavioral health needs. The UM Program must be evaluated, and updated if necessary, at least annually.

b. Authorization processes for specialty referral, specified diagnostic or therapeutic services, home health, elective surgeries, etc.

c. Coordination of care and discharge planning with IEHP UM for inpatient Members as applicable.

d. Management of out-of-network emergency for Members.

e. Availability of UM staff, at least eight (8) hours a day during normal business days, to respond to Providers and practitioners regarding UM issues.

f. Process to track open and unused referrals.

2. Delegate UM Medical Director - There must be a designated senior-level physician who holds an unrestricted license in the state of California, responsible for reviewing and monitoring the UM process, including at a minimum, the following activities:

a. Final decision making on referrals denied or partially approved (modified) for medical necessity or benefit coverage;

b. Review of all partially approved or denied referrals to assure consistent processes and decision making;

c. Review of internal physician-specific UM data to assess potential over and under utilization of services;

d. Sign-off on all internal policies and procedures related to UM; and

e. Chairing the UM Committee, or designating a Chair.

3. Delegate UM Committee - Committee membership must include a minimum of three (3) practicing physicians from the Delegate, representing the appropriate specialties pertinent to IEHP Membership including Obstetrics and Gynecology (OB/GYN), Pediatrics, Family Practice and other specialists, as needed. The UM Committee must meet at least quarterly and perform at a minimum the following activities:

a. Concurrent review of complex referrals requiring multiple physician input;

b. Retrospective review of approved and denied referrals to assess consistency of process and decisions;

c. Review of physician-specific UM data to assess potential under and over utilization; and

d. Review of appeals or grievances related to UM decisions, as needed, with referral to QM or Peer Review Committee as appropriate.
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4. Delegate UM Program Description must include:
   a. Mission statement, goals, and objectives;
   b. Designated standards used for determination of medical necessity that meet IEHP requirements;
   c. Authorization process, in detail, including staffing and IEHP’s mandated turnaround timeframes;
   d. Evidence of full range of UM activities;
   e. UM Committee meeting frequency;
   f. UM Committee chairperson and membership including a rotation policy;
   g. Documentation of ability to collect and report all required UM data;
   h. Delineation of timeframes for approval or denial of referrals that meet IEHP standards;
   i. Denial process that includes letters to Members, practitioners and monthly log report to health plans;
   j. Procedures for informing practitioners of referral process; and
   k. Dissemination of summary and UM data to practitioners.

5. Network Practitioner Responsibilities: Network practitioners are required to follow established UM procedures for authorization that include:
   a. Providing sufficient information for decision making; and
   b. Following Delegate directions for initiating the UM process.

D. Use of Appropriate Professionals for UM Decisions: To ensure that first-line UM decisions are made by individuals who have the knowledge and skills to evaluate working diagnoses and proposed treatment plans, IEHP has adopted standards for personnel making review decisions and reviewing denials. The following types of personnel can perform the functions listed:

1. For medical decisions:
   a. UM Technicians/Coordinators – eligibility determination, editing of referral form for completeness, interface with practitioner office to obtain any needed non-medical information and auto authorizations as indicated per the Delegate’s policies.
   b. RN/LVN – initial review of medical information, initial determination of benefit coverage, obtaining additional medical information, as needed, from practitioner office, approval of medically routine referrals, preliminary denial for eligibility.
   c. A physician must supervise review processes and decisions.
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d. A designated, California licensed physician must review all the Delegate’s denials for medical necessity and obtain additional medical information from treating physician, as needed within the required timeframes. A designated Board Certified physician in the appropriate specialty must be consulted to review all applicable denied referrals and approve complex referrals, as needed.

e. Compensation arrangements for individuals who provide utilization review services must not contain incentives, direct or indirect, to make inappropriate review decisions. If incentives are used, the Delegate must demonstrate that there is a mechanism in place to ensure that all decisions are based on sound clinical judgment.

f. Delegates that utilize referral decision-making and hospital length of stay information for economic profiling must provide documentation to their PCPs and IEHP, if requested.

2. Use of Board Certified Physicians for UM Decisions: IEHP and its Delegates use designated physicians with current unrestricted license for UM decisions. When a case review falls outside the clinical scope of the reviewer, or when medical decision criteria do not sufficiently address the case under review, a Board Certified physician in the appropriate specialty must be consulted.

a. All Delegates are required to have a written policy and procedure in place that addresses the process for the use of Board Certified Specialists for UM decisions.

b. Delegates are required to either maintain lists of specialists to be utilized for UM decisions, or consult with an organization contracted to perform such review. The interaction can be completed by a telephone call to a network specialist, a written request for review, or use of a contracted vendor that provides Board Specialist review.

c. The primary physician reviewer determines the type of specialty required for consultation.

d. IEHP maintains a contract with one or more external review companies, for specialty consultation.

E. Authorization, Inpatient Review, and Notification Standards: Mandated timeframes for decisions including approval, denial or partial approval (modification) of a request and subsequent notification to the Member and practitioner are outlined below. For further details regarding pharmaceutical pre-authorization guidelines, see Policy 11B, “Prior Authorization for Non-Formulary Medications.”

1. Communication Services: The Delegate must provide access to staff for Members and practitioners seeking information about the UM Process and the authorization of care. This includes the following:
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a. Delegate UM staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues;

b. Outbound communication from staff regarding inquiries about UM during normal business hours;

c. Staff identify themselves by name, title, and organization when initiating or returning calls regarding UM issues;

d. Staff can receive inbound communication regarding UM issues after normal business hours;

e. Staff are accessible to callers who have questions about the UM process; and

f. IEHP and its Delegates are responsible for assuring TDD/TTY services for the deaf, hard-of-hearing, or speech impaired, and language assistance are available to all IEHP Members. IEHP will audit to assure that all policies and procedures state that Delegates have these services in place.

2. Authorization and Notification for Referrals or Services: Authorization and notification of decision for proposed services, referrals, or hospitalizations at the practitioner level involves utilizing information such as medical records, test reports, specialist consults, and verbal communication with the requesting practitioner in the review determination. Part of this review process is to determine if the service requested is available in network. If the service is not available in network, arrangements are made for the Member to obtain the service from a non-network provider for this episode of care. Prior authorization for all outpatient services and elective admissions should take place at an IEHP network facility.

When the service required appears to be unavailable within the IEHP Network, the Delegate must send the request to IEHP. If IEHP determines the requested service cannot be provided within the network, IEHP will initiate the Letter of Agreement (LOA) process, which may take one to two (1-2) days to complete. It is therefore, critical that the Delegate fax the referral with all supporting documentation as soon as possible to (909) 890-5751 to prevent a possible delay of care.

a. Prior Authorization of Non-urgent Pre-Service Decisions:

1) The prior authorization process is initiated when the Member, Member’s representative, or the Member’s physician requests a referral or authorization for a procedure or service with the exception of vision services or hospitalization.

2) The timeframes for completion and adjudication of the referral are as follows:
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- **Practitioners** have **two (2) working days** from the determination that a referral is necessary to submit the referral and all supporting documentation. Practitioners must sign and date the referral and provide a direct telephone number and fax number to the referring physician for any questions or communication regarding the referral.

- The **Delegate’s** decision to approve, partially approve (modify), deny, or terminate must be made within **five (5) working days** from receipt of the request. If additional information is necessary in order to make a determination, the Delegate should contact the requesting practitioner for the additional clinical information within twenty-four (24) hours, preferably by phone. The Delegate must annotate that additional information has been requested, include the date of the request and conclude the decision process within five (5) working days of receiving the request.

- Practitioners must be initially notified within twenty-four (24) hours of the decision by telephone, if the practitioner cannot be reached by telephone, a fax can be utilized. Telephonic communications of decisions must be documented including date, time, name of contact person, and initials of person making the call.

- Both the Member and practitioner must be notified of all decisions by the Delegate, in writing, within two (2) working days of the determination.

b. **Prior Authorization for Emergent/Urgent Pre-Service Decisions:**

1) Prior authorization is not required for emergent services. Emergent services are defined by the prudent layperson as:

- A medical condition exists which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in:
  - 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; or
  - Serious impairment to bodily function; or
  - Serious dysfunction of any bodily organ or part.
2) Prior authorization is not required for services necessary to treat and stabilize an emergency medical condition.

3) Practitioners must submit urgent referrals the same day of the determination that the referral is necessary. Decisions to approve, partially approve (modify), or deny authorization for urgent services must be completed within **seventy-two (72) hours** (includes weekends and holidays) of receipt of the request.
   - The Delegate has forty-eight (48) hours after receipt of an urgent request to determine if it is non-urgent.
   - The Delegate RN/LVN reviewer or physician reviewer must communicate the change to non-urgent status by phone or fax.
   - Telephonic communication must be documented, including date, time, name of contact person at the practitioner’s office, name of the RN/LVN, or physician reviewer.
   - Fax communication to the practitioner should state that the request did not meet the definition of urgent pre-service:
     - Delay could seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function, based on a prudent layperson’s judgment; or
     - In the opinion of a practitioner with knowledge of the Member’s medical condition, would subject the Member to severe pain that cannot be adequately managed without the requested care or treatment.

4) Practitioners must be initially notified within twenty-four (24) hours of the decision by telephone or fax. The Member may be initially notified of the denial decision within seventy-two (72) hours of the receipt of the request. Telephonic communications of decisions must be documented including date, time, name of contact person, and initials of person making the call.

5) Both the Member and practitioner must be notified of all decisions by the Delegate, in writing, within seventy-two (72) hours from receipt of the request. If the Member receives oral notification within seventy-two (72) hours of the receipt of the request, written or electronic notification must be given no later than three (3) calendar days after the initial oral notification.

6) The Delegate must notify both the practitioner and Member utilizing the IEHP approved “Notice of Action” template and
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provide “Your Rights” attachment(s) with all denials that instructs a Member or Member representative on the appeal/grievance process. These IEHP approved notification templates are available online at: [https://ww3.iehp.org/en/providers/forms/um-forms/medical/](https://ww3.iehp.org/en/providers/forms/um-forms/medical/).

c. Post-Service Decisions (Retrospective Review):

1) Services rendered without prior authorization require retrospective review for medical necessity and/or benefit coverage. This can include out-of-area admissions and/or services or treatments rendered by a contracted or non-contracted practitioner/provider without prior authorization.

2) Relevant clinical information must be obtained and reviewed for medical necessity based on approved clinical criteria. If medical necessity is not met, denial determinations must be made by the Delegate Medical Director.

3) Retrospective review decisions and written notification to the Member and practitioners must be made within thirty (30) calendar days from receipt of the request.

4) Members do not need written notification of the decision in the following situations:
   - Retrospective review is only to determine payment level; or
   - The Member is not at financial risk.

   [For example, a retrospective billing adjustment of an Emergency Department visit does not require Member notification because the services have already been rendered, the Member is not financially impacted by the decision, and payment must be made for the medical screening exam (MSE).]

d. Experimental and Investigational Determinations:

1) The determination for all experimental and investigational services is the responsibility of IEHP. All authorization requests for experimental/investigational services must be sent as soon as possible after receipt by facsimile to IEHP, attention Medical Director at fax number (909) 890-5751, using the Health Plan Referral Form for Out-of-Network and Special Services (See Attachment, “Health Plan Referral Form for Out-of-Network/Special Services” in Section 14). The request must include all supporting clinical information including diagnosis (ICD codes) and procedure (CPT) codes. IEHP is responsible for
decision-making and notifying the Provider, Member and Delegate of the determination, per standard timeframes for level of urgency.

2) If there is an IEHP UM Subcommittee Clinical Authorized Guideline (CAG) regarding the requested experimental/investigational service, the Delegate can cite the guideline and issue on the Notice of Action (NOA) letter.

e. **Denial Notices**: Any denial, in whole or in part, of a requested health care service must be reviewed and approved by the Delegate UM Medical Director, physician designee, or UM Committee. Members must receive an approved Notice of Action (NOA) letter including all Your Rights and required attachments for any requested referral that is denied, partially approved (modified), or terminated as appropriate. The Delegate is responsible for notifying Members of the reason for denial and citing the criteria or benefit coverage information used to render the decision. Any denial notices regarding experimental investigational therapy are the responsibility of IEHP, as stated above.

f. **Denial letters must include the following** (IEHP approved notification templates are available online at: [https://ww3.iehp.org/en/providers/forms/um-forms/medical/](https://ww3.iehp.org/en/providers/forms/um-forms/medical/)):

1) Required Department of Managed Health Care (DMHC) language (in bold within sample);

2) Required Department of Health Care Services (DHCS) language;

3) The right to appeal the decision, file a grievance, ask for an Independent Medical Review (IMR), refer to “Your Rights”;

4) Language appropriate for the Member population describing the reason for the denial;

   • Medical necessity denials must cite the criteria used and the reason why the clinical information did not meet criteria;

   • Non-covered benefit denials must cite the specific provision in the explanation of coverage (EOC) that excludes that coverage (i.e. the IEHP Member Handbook) or State or Federal regulations including the page number and/or give the State or Federal Regulations section; and

   • Information on how the Member and practitioner can obtain the utilization criteria or benefits provision used in the decision.

5) Information for the Member regarding alternative direction for follow-up care or treatment.
The written communication to a practitioner of a denial based on medical necessity must include the name and telephone number of the UM Medical Director or physician designee responsible for the denial. Such communication must offer the requesting practitioner the opportunity to discuss any issues or concerns regarding the decision within seventy-two (72) hours of the initial notification of the denial or partial approval (modification). This written notification of denial or partial approval (modification) must include language informing the practitioner that they can appeal the decision to the Delegate Medical Director, IEHP Chief Medical Officer or the IEHP Medical Director. If the practitioner chooses to appeal the denial or partial approval (modification) to the Delegate and the Delegate upholds the original decision, the subsequent letter must inform the practitioner of their right to submit a formal appeal to the IEHP Grievance and Appeals Department. If the Delegate upholds the denial or partial approval (modification) of an urgent referral, the Delegate must send all information to IEHP’s Medical Director for review, no later than one (1) business day following the decision to uphold the denial or partial approval (modification).

On a monthly basis for monitoring purposes as outlined in Policy 14B, “Utilization Management Reporting Requirements” the Delegate must send IEHP all documentation for each denial including the following:

1) Denial log;
2) Letters and attachments;
3) Clinical documentation;
4) Referral;
5) Criteria used for the determination; and
6) Initial notification including opportunity to discuss.

IEHP and its Delegates shall retain information on decisions, e.g., authorizations, denials, appeals, grievances, or partial approvals (modifications) for a minimum period of ten (10) years.

Exceptions: Prior authorization is not required for the following services:

1) Family Planning;
2) Abortion Services;
3) Sexually transmitted disease (STD) treatment;
4) Sensitive and Confidential Services;
5) HIV testing and counseling at the Local Health Department;
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6) Immunizations at the Local Health Department; and
7) Routine OB/GYN services, including prenatal care by Family Care practitioner (credentialed for obstetrics) within the IEHP network.

3. **Emergency Services:** Prior authorization is not required for the medical screening exam (COBRA exam) performed at an Emergency Department or for services necessary to treat and stabilize a life-threatening emergency. IEHP has adopted the following definition for an emergency medical condition:

a. 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:
   1) 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; or
   2) Serious impairment to bodily function; or
   3) Serious dysfunction of any bodily organ or part.

b. For further details see Policy 14F, “Emergency Services.” All emergency care costs are covered when authorized by IEHP, or its designee, or a Delegate representative.

4. **Managing Referrals:** Delegates are required to have procedures by which a PCP may request a standing referral to a specialist for a Member who requires continuing specialty care over a prolonged period of time or an extended referral to a specialist for a Member who has a life threatening, degenerative, or disabling condition that requires coordination of care by a specialist. Delegates must have a system in place to track open, unused; and standing referrals/Members and must authorize care for a three to six (3-6) month period.

5. **Behavioral Health:** Behavioral Health benefits are a shared risk between IEHP and the respective County Behavioral Health Services program. Please refer to Policy 12.K.1, “Behavioral Health Services” for more information.

6. **Vision Services:** IEHP is responsible for UM associated with vision services for Medi-Cal Members.

7. **Pharmacy Services:** IEHP does not delegate the responsibility for UM associated with pharmacy services. Please refer to Section 11, “Pharmacy,” for further details.

F. **Delegated UM Requirements** – Delegates must meet the following requirements for UM processes:
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1. **Services Requiring Prior Authorization:** Each Delegate must maintain a list of services that require prior authorization or have a list of services that do not require prior authorization.

2. **Medical Necessity Determination:** Delegates must determine medical necessity for a specific requested service as follows:
   
a. Utilize a definition for medical necessity which includes all health care services necessary for the diagnosis and/or treatment of a medical condition causing significant pain, negative impact on the health status of the Member, potential disability or is potentially life threatening;

b. If information reasonably necessary to make a determination is not available with the referral, the requesting practitioner should be contacted for the additional clinical information by telephone at least two (2) times and if deemed necessary, by a Medical Director.

c. Employ IEHP approved UM standards including IEHP UM Subcommittee Approved Authorized Guidelines, Milliman Care Guidelines, InterQual, and Apollo Managed Care Guidelines/Medical Review Criteria;

d. Take into account all factors related to the Member including barriers to care related to access or compliance, impact of a denial on short and long term medical status of the Member and alternatives available to the Member if denied; and

e. Obtain input from specialists in the area of the health care services requested either through a UM Committee member, telephonically, or use of an outside service.

3. **Denials because the requested service or procedure is not a covered benefit:** The IEHP Benefit Manual and other supporting regulations must be utilized to determine if a requested service or procedure is a covered benefit.

4. **Denials due to the Member not being eligible:** Current eligibility or eligibility for the time period that services were rendered, should be verified to determine if the Member is eligible.

5. **Denial due to lack of documentation:** The Delegate must include in the denial letter to the Member and Provider the specific clinical criteria necessary to meet the requirements (e.g. diagnosis, labs, premiums, treatments, etc).

6. **Referral Requests:** The PCP provides general medical care for Members. Referral to specialists, or authorization for procedures, services, or hospital admissions, should be initiated by PCPs through the Member’s delegated IPA. Specialists caring for Members can request referrals directly from the delegate IPA.
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G. Documentation of Medical Information and Review Decisions: Delegates must base review decisions on documented evidence of medical necessity provided by the attending physician. Regardless of criteria, the Member’s condition must always be considered in the review decision.

1. Physician Documentation: Attending physicians must maintain adequate medical record information to assist the decision-making process. The PCP must document the medical necessity for requested services, procedures, or referrals and submit all supporting documentation with the request.

2. Reviewer Documentation: Delegate reviewers must abstract and maintain review process information in written format for monitoring purposes. Documentation must be legible, logical, and follow a case from beginning to end. Rationale for approval, partial approval (modification) or denial must be a documented part of the review process. Decisions must be based on clinical information and sound medical judgment with consideration of local standards of care.

3. Delegate Documentation: Delegates must have a procedure in place to log requests by date and receipt of information so that timeframes and compliance with those timeframes can be tracked. Delegate documentation of authorizations or referrals must include, at a minimum: Member name and identifiers, description of service or referral required, medical necessity to justify service or referral, place for service to be performed or name of referred physician, and proposed date of service. Documentation must also include a written assessment of medical necessity, appropriateness of level of care, and decision. Any denial of a proposed service or referral must be signed by the Delegate’s UM Committee, Medical Director, or physician designee. Written notifications to a practitioner of a denial must include the name and telephone number of the UM Medical Director or physician designee responsible for the denial.

4. Affirmative Statement Regarding Incentives: UM decisions for Members must be based only on appropriateness of care and existence of coverage. IEHP does not provide compensation for practitioners or other individuals conducting utilization review for issuing denials of coverage or service. IEHP ensures that IEHP or Delegate contracts with physicians do not encourage or contain financial incentives for denial of coverage or service that result in underutilization. The Affirmative Statement about incentives is distributed annually to all practitioners, Providers, employees, and Members.

5. Prohibition of Penalties for Requesting or Authorizing Appropriate Medical Care: Physicians cannot be penalized in any manner for requesting or authorizing appropriate medical care.

6. Discharge Planning: The UM process must include coordination of care with IEHP and facilities the following activities related to discharge planning:
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a. Arranging necessary follow-up care (home health, follow-up PCP or specialty visits, etc); and

b. Facilitating transfer of the discharge summary and/or medical records, as necessary, to the PCP office.

7. Out of Network Management: Delegates must assist with the transfer of Members, as medically appropriate, back into the IEHP network during an inpatient stay, as applicable.


   a. UM data reported includes, at a minimum, the following:

      1) Enrollment;
      2) Re-admits within thirty (30) days of discharge;
      3) Total number of prior authorization requests;
      4) Total number of denials;
      5) Denial percentage; and
      6) Emergency encounters.

   b. Presentation of above data in summary form to the Delegate’s UM Committee for review and analysis at least quarterly upon receipt of necessary information;

   c. Presentation of selected data from above to the Delegate PCPs, specialists, and/or Hospitals as a group, e.g., Joint Operating Meetings (JOMs), or individually, as appropriate; and

   d. Evidence of review of data above by the Delegate’s UM Committees for trends by physicians for both over-utilization and under-utilization.

H. Grievance Process: IEHP maintains a formal Grievance Resolution System to ensure a timely and responsive process for addressing and resolving all Member grievances and appeals. IEHP acknowledges and resolves UM related grievances and appeals in accordance with state and federal regulatory guidelines. The Member may file a grievance by phone, by mail, fax, website, or in person. Please refer to Section 16, “Grievance Resolution System.”

I. Second Opinions: Members, PCPs and specialists have the right to request a second opinion regarding proposed medical or surgical treatments from any participating practitioner within their Delegate’s network. Second opinions are authorized and arranged through the Member’s assigned Delegate’s authorization system. In cases in which the Member faces imminent and serious threat to his/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
A. Utilization Management Delegation and Monitoring

function, decisions and notification of decisions to practitioner are completed in a timely fashion not to exceed seventy-two (72) hours after receipt of request. If the referral for a second opinion is approved, the Delegate must make arrangements for the Member to see a physician in the appropriate specialty. If the referral is denied, the Delegate must provide written notification to the Member including rationale for the denial. Members disagreeing with a denial of a second opinion may register a grievance through the IEHP grievance process. Refer to Policy 14E, “Second Opinions,” for more information.

J. New Technology: The IEHP UM Subcommittee is responsible for reviewing new medical technologies and new applications of existing technologies for potential addition as a medical benefit for Members. The IEHP Chief Medical Officer or Medical Director will identify and research new technology and new applications of existing technologies, including medical procedures, treatment, and devices. Research and investigation includes review of scientific information, such as ECRI’s Health Technology Information Services, and review of regulatory body publications from such agencies as the FDA. Information is then presented to the UM Subcommittee regarding the technology/product, its scope and limitations. The UM Subcommittee obtains an opinion from an appropriate specialist physician whenever necessary to assist in the decision regarding coverage of a new technology as a covered benefit for Members. Once approved by the UM Subcommittee, the IEHP Chief Medical Officer or Medical Director presents the new benefit/service, including scope and limitations, to the IEHP QM Committee for approval.

K. Satisfaction with the UM Process: At least annually, IEHP performs Member and Physician Satisfaction Surveys as a method for determining barriers to care and/or satisfaction with IEHP processes including UM.

L. Delegated UM Responsibilities: IEHP delegates all aspects of UM activities related to medical services for assigned Members to Delegates. All medical services are arranged for or provided by professional personnel and at physical facilities according to professionally recognized standards of medical practice and healthcare management. Delegate medical services must be rendered by qualified medical practitioners, unhindered by fiscal and administrative management. All Delegates must further agree to provide or arrange for referrals to specialists and facilities as are necessary, appropriate, and in accordance with generally accepted managed care industry standards of medical practice, in compliance with the standards developed by IEHP and NCQA.

M. Non-delegated UM Responsibilities: IEHP retains responsibility for selective UM activities for non-covered benefits, authorizations for vision services, pharmacy services, foster children in the Open Access program, and behavioral health authorizations. A medical management software system is maintained to accommodate authorizations by IEHP for services that are not covered under the Medi-Cal Managed Care contract but are authorized by the IEHP Chief Medical Officer or Medical Director. Examples include special lenses, abortions under special circumstances, or special referrals/treatment out-of-network.
14. UTILIZATION MANAGEMENT

A. Utilization Management Delegation and Monitoring

N. Monitoring Activities and Oversight: IEHP monitors and oversees delegated UM activities performed by the Delegates. The following oversight activities are performed to ensure compliance with IEHP UM standards:

1. Delegate and Hospital Contracts – The IEHP Agreements contain language that designates compliance requirements for participation in an ongoing utilization management program to promote efficient use of resources.

2. Delegation Oversight Audits (DOA) – IEHP performs a Delegation Oversight Audit of all Delegates to review the Delegate’s UM policies, procedures, and activities. This audit re-assesses the Delegate’s operational capabilities in the areas of QM, Medical Records, Preventive Health, Members’ Rights and Responsibilities, Credentialing, UM, and Care Management. Please refer to Policy 13E, “Delegation Oversight Audit,” for further details.

3. Analysis of Provider Data Reports – The Delegation Management Nurse and Director of Quality Management or designee reviews required IEHP and Delegate reports and utilization data including second opinion tracking logs, denial logs and letters, and annual and semi-annual work plans.

4. Review of Approvals and Denials – All Delegates are required to submit monthly denial and approval logs along with ten (10) sample approvals (See Attachment, “Monthly Denial Listing” in Section 14). Ten (10) denial files including partial approvals (modifications) from the previous month are randomly selected from the monthly denial log. Delegates are required to submit copies of all approvals and denial letters sent to Members and to practitioners. If the practitioner appeals a denial to the Delegate, and the Delegate upholds the decision, the notification letter sent to the practitioner, regarding the upheld decision, must be submitted to IEHP with the monthly submission of denials. All denials are reviewed for appropriateness by the Delegation Management Nurse, Director of Quality Management, Quality Management Manager, or designee.

5. Focused Referral and Denial Audits: IEHP performs focused audits of the referral and denial process for Delegates. Please refer to Policy 14D, “Referral and Denial Audits.” Audits examine source data at the Delegate to determine referral process timelines and appropriateness of denials and the denial process, including denial letters.

6. Member or Practitioner Grievance Review: IEHP performs review, tracking, and trending of Member or practitioner grievances and appeals related to UM. IEHP reviews Delegate grievances and recommended resolutions for policies, procedures, actions, or behaviors that could potentially negatively impact Member health care.

7. Joint Operating Meetings (JOMs): JOMs are intended to provide a forum to discuss issues and ideas concerning care for Members. They allow IEHP a method of monitoring plan administration responsibilities delegated to IPAs.
14. UTILIZATION MANAGEMENT

A. Utilization Management Delegation and Monitoring

JOMs may address specific Provider Services, UM, QM, CM, grievance, study results, or any other pertinent quality issues affecting practitioners, hospitals or Delegates. They are held with Delegates and IPA/hospital relationships, as applicable. These meetings are designed to address issues from an operational level.

O. Enforcement/Compliance: IEHP monitors and oversees delegated UM activities performed by Delegates. Enforcing compliance with IEHP standards is a critical component of monitoring and oversight of IEHP Providers, particularly related to delegated activities.

P. Confidentiality: IEHP recognizes that Members’ confidentiality and privacy are protected. It is the policy of IEHP and its Delegates to protect the privacy of individual Member health information by permitting UM staff to obtain only the minimum amount of Protected Health Information (PHI) necessary to complete the healthcare function of activity for Member treatment, payment or UM operations.

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14. UTILIZATION MANAGEMENT

B. Utilization Management Reporting Requirements

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. All Delegates must report Utilization Management (UM) information to IEHP as described below on a monthly, semi-annual, and annual basis.

B. Delegate reports must be received by IEHP electronically using a Secure File Transfer Portal (SFTP) server.

C. Reports are due on or before the due dates regardless if the due date is a weekend or a holiday.

DEFINITION:

A. For the purpose of this policy, a “Delegate” is defined as a medical group, IPA, or any contracted organization delegated to provide utilization management (UM) services.

PROCEDURES:

A. Skilled Nursing Facility (SNF) Admissions:
   1. All Delegates must notify IEHP of all SNF admissions from the previous month by the 15th of the month and/or as soon as it is determined the Member will transmit to custodial care.
      a. Long Term Care (LTC) Data Sheet – Delegates must include all data listed on the “LTC Data Sheet” (See Attachment, “LTC Data Sheet” in Section 14). Send LTC Data Sheet along with factsheet to IEHP’s Long Term Care fax line at (909) 477-8553.

B. Monthly Reporting Requirements:
   1. Reporting requirements include a monthly assessment of utilization data and denial activity. Monthly reports are due to IEHP by the 15th of the month following the month in which services were rendered or denials made, and include the following:
      a. Denials and Partial Approvals (Modifications) – Must be submitted in excel file format and include all referral and clinical information, and copies of all denial letters included on the “Monthly Denial Listing” (See Attachment, “Monthly Denial Listing” in Section 14). Partial approvals (modifications) occur when a decision is made and proposed care is denied or altered. The standard denial rate will be 5% overall, which may include non-benefit, out-of-network, etc., and 3% for medical necessity
14. UTILIZATION MANAGEMENT

B. Utilization Management Reporting Requirements

denials.

1) Definitions of Decision:

- **Partial Approval (modified) w SLC** (service level change)-A service request is being modified based on clinical information received to a more appropriate service, or the requested number of services is being decreased. Example: request for podiatry is being modified to orthopedics; fourteen (14) physical therapy visits is being reduced to seven (7).

- **Partial Approval (modified) w NSLC** (no service level change)-No services are being modified, only who is providing them. Used for out-of-network modifications. Example: referral to a non-contracted specialist directed to the same type specialist in contracted network.

- **Not Medically Necessary**- Does not meet approved nationally recognized criteria or IEHP UM Subcommittee guidelines.

- **Out-of-Network**- Services requested for non-contracted provider

- **CCS**- Services carved out to California Children’s Services. Member must have an open, active case for the service requested.

- **Care in Alternate Setting**- Service is available in a setting that may not be medical in nature. Example: Child is sent to the Inland Regional Center (IRC) or school district for request for speech therapy.

- **Experimental**- Request for service that has not been FDA approved and/or is not an accepted practice in the medical community and/or has not been proven to have a therapeutic benefit.

- **Non-Benefit**- Not a covered benefit.

b. **Second Opinion Tracking Log** – Include all authorizations, partial approvals (modifications), and denial information for second opinion requests. The Log must include the reason the second opinion was requested (See Attachment, “Second Opinion Tracking Log” in Section 14).

c. **Approval File Review** – Submit referral log along with ten (10)
complete Approval Letters with the supporting documentation used to make the decisions – monthly (due at the 15th of the month)

B. **Semi-Annual Reporting Requirements:**

1. UM Semi-Annual Reports must be submitted to IEHP by the 15th of the month following months, February and August. The reports should include, at a minimum, UM goals and activities, trending of utilization activities for under and over utilization, Member and practitioner satisfaction activities, and inter-rater reliability activities and improvement. The Semi-Annual report due in February must also include the UM Program Annual Evaluation that is the IPA’s evaluation of the overall effectiveness of the UM Program, including whether or not goals were met.

C. **Annual Reporting Requirements:** The following reports must be submitted annually to IEHP by the last day of February of each calendar year:

1. **UM Program Description:** Reassessment of the UM Program Description must be done on an annual basis by the UM Committee and/or QM Committee and reported to IEHP including the following:
   a. Any changes made to the UM Program Description during the past year or intended changes identified during the annual evaluation; and
   b. UM Program Description Signature Page.

2. **UM Work Plan:** Submit an outline of planned activities for the coming year, including timelines, responsible person(s) and committee(s). The Work Plan should include measurable goals, planned audits, follow-up activities and interventions related to identified problem areas.

D. All reports must be submitted to IEHP within the timeframes specified via IEHP’s Secure File Transfer Portal (SFTP server).

E. Persistent failure to submit required reports may result in action that includes, but is not limited to, request for Corrective Action Plan (CAP), freezing of new Member enrollment, termination or non-renewal of the IEHP Agreement.

F. Any discrepancies in reported information are addressed with the IPA in accordance with monitoring activities outlined in Policy 14A, “Utilization Management Delegation and Monitoring.”

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14. UTILIZATION MANAGEMENT

C. Review Procedures
   1. Primary Care Physician (PCP) Referrals

APPLIES TO:
A. This policy applies to all IEHP Medi-Cal 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 Delegated entity’s referral process.
C. Delegates are responsible for the processing, tracking, and reporting of referrals as specified by IEHP.

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

PROCEDURES:
A. Referrals to specialists, second opinions, elective hospital admissions, or any service which require prior authorization are initiated by PCPs or specialists through the Delegate for delegated services. Prior authorization for proposed services, referrals, or hospitalizations involve the following:
   1. Verification of Member eligibility by the Delegated entity;
   2. Written documentation by the PCP or specialist of medical necessity for service, procedure, or referral;
   3. Verification by the Delegated entity 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 Delegates for approval, in accordance with Policy 14C1a, “Review Procedures – Primary Care Physician (PCP) Referrals– PCP Referral Tracking Log.” The prior authorization/referral process must meet all standards, including timeliness, as delineated in Policy 14A, “Utilization Management Delegation and Monitoring.” The Referral Tracking Log is reviewed and monitored during PCP Site Review and Medical Record Review Survey and Interim Audits or as required in accordance with Policy 7A, “PCP and IPA Medical...
14. UTILIZATION MANAGEMENT

C. Review Procedures
   1. Primary Care Physician (PCP) Referrals

Record Requirements”.

C. Decisions for routine referrals must be made within five (5) working days of receipt of request. Decisions for urgent referrals must be made within seventy-two (72) hours of receipt of request.

D. The PCP informs Members that if the referral is denied or partially approved (modified), they can file an appeal/grievance with IEHP. A written notice of denial that includes the appeal/grievance process must be provided.

E. Referrals to specialists or out-of-network practitioners require documentation of medical necessity, rationale for the requested referral, and prior authorization from the Delegate. 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 the Delegate, must first obtain prior authorization through the Delegate.

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 report 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 with oversight by IEHP.

G. Denial logs and letters for in-network and out-of-network denials and partial approvals (modifications) must be maintained by the Delegate. Denial logs and letters must be sent to IEHP on a monthly basis for monitoring purposes. Information on the denial logs must include at a minimum: Member name, IEHP number, requesting physician name, date of referral or request, the specifics of referral or request, diagnosis, decision by Delegate [approval, denial, or partial approval (modification) specifics], alternatives offered, and date of decision.

H. IEHP reserves the right to perform site audits or to verify accuracy of information on referral logs by examining source information.

I. Referrals for behavioral health services for all IEHP Members are initiated by the PCP or Delegate through IEHP. Refer to Policies 12K1, “Behavioral Health - Behavioral Health Services” and 12K2, “Behavioral Health - Alcohol and Drug Treatment Services.”
14. UTILIZATION MANAGEMENT

C. Review Procedures
   1. Primary Care Physician (PCP) Referrals
14. UTILIZATION REVIEW

C. Review Procedures
   1. Primary Care Physician (PCP) Referrals
      a. Referral Tracking Log

APPLIES TO:
A. This policy applies to all IEHP Medi-Cal Members.

POLICY:
A. All Primary Care Physicians (PCPs) are required to maintain a system for tracking all referrals submitted to their IPAs for Members.

PROCEDURES:
A. All PCPs must maintain a referral log that contains all of the information noted below:
   1. IPA auth/tracking number;
   2. Member name;
   3. Member IEHP ID number;
   4. Member date of birth;
   5. Acuity of referral (Urgent or Routine);
   6. Reason for referral or diagnosis;
   7. Service/Activity Requested;
   8. Date referral returned;
   9. Requesting Provider;
  10. Requested Provider;
  11. Requested Provider specialty; and
  12. Referral decision.

B. PCPs may either use the IEHP Referral Tracking Log (See Attachment, “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 and 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

C. Review Procedures
   1. Primary Care Physician (PCP) Referrals
      a. Referral Tracking Log
14. UTILIZATION MANAGEMENT

C. Review Procedures
   2. Standing Referral/ Extended Access to Specialty Care

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. Delegates 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 Certified 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 (800) 440-4347 or for TTY (800) 718-4347.

D. PCPs are responsible for coordinating the care of the Member in consultation with the specialist, Delegated entity and Member.

DEFINITION:

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

PROCEDURES:

A. Delegates 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 as needed, within three (3) business days 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 the Delegate
14. UTILIZATION MANAGEMENT

C. Review Procedures
   2. Standing Referral/Extended Access to Specialty Care

   in writing, using the designated form within four (4) business days (See Attachment, “Standing Referral/Extended Access 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.”

D. If the Delegate determines that the standing referral should be limited in terms of number of visits or timeframe, the Delegate, in consultation with the PCP and specialist, must develop a treatment plan specifying the limits. The treatment plan must be approved by IEHP.

E. Treatment plans must be submitted to IEHP Medical Director by fax at (909) 890-5538. IEHP must make its determination regarding the treatment plan within three (3) business days.

F. Standing referrals or extended access to specialty care approved without limitations do not require a treatment plan or IEHP approval.

G. 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. GI conditions such as severe peptic ulcer, chronic pancreatitis among others.

H. 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;
14. UTILIZATION MANAGEMENT

C. Review Procedures
   2. Standing Referral/ Extended Access to Specialty Care

6. Potential transplant candidates;
7. Severe and progressive neurological conditions;
8. Renal failure; and
9. Cystic fibrosis.

I. 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. An HIV/AIDS specialist is a physician who holds a valid, un-revoked and unsuspended license to practice medicine in the state of California who meet any one (1) of the following four (4) criteria:

1. Is credentialed as an “HIV Specialist” by the American Academy of HIV Medicine (AAHIVM); or
2. Is board certified, or has earned a Certificate of Added Qualification in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a certificate of Added Qualification in the field of HIV medicine; or
3. Is board certified in the field of infectious diseases and meets the following qualifications:
   a. In the preceding twelve (12) months has clinically managed medical care to a minimum of twenty-five (25) patients who are infected with HIV; and
   b. In the preceding twelve (12) months has successfully completed a minimum of fifteen (15) hours of Category 1 continuing medical education, (as directed by the Medical Board of California), in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of five (5) hours related to antiretroviral therapy per year; or
4. Meets the following qualifications:
   a. In the preceding twenty-four (24) months has clinically managed medical care to a minimum of twenty (20) patients who are infected with HIV; and
   b. Has completed any of the following:
      1) In the preceding twelve (12) months has obtained board certification or recertification in the field of infectious diseases; or
      2) In the preceding twelve (12) months has successfully completed a minimum thirty (30) hours of Category 1 continuing medical
education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or

3) In the preceding twelve (12) months has successfully completed a minimum of fifteen (15) hours of Category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the AAHIVM.

J. The HIV/AIDS specialist may utilize the services of a nurse practitioner or physician assistant if:

1. The nurse practitioner or physician assistant is under the supervision of an HIV/AIDS specialist;
2. The nurse practitioner or physician assistant meets the qualifications specified in this policy; and
3. The nurse practitioner or physician assistant and the supervising HIV/AIDS specialist have the capacity to see an additional patient.

K. The Delegate is not required to refer the Member to a non-network provider unless there is no HIV/AIDS specialist, or appropriately qualified nurse practitioner or physician assistant under the supervision of an HIV/AIDS specialist within the network appropriate to provide care to the Member, as determined by the Delegate’s Medical Director and/or PCP in consultation with IEHP’s Chief Medical Officer, when warranted.

L. Any medical condition requiring frequent or repeat visits to a specialist should be considered for standing referral or extended access, if the Member request 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 regarding submission of a standing referral to IEHP or the Delegate. This determination should be made after consulting with the Member’s 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 Delegate within four (4) business days, using the designated form (See Attachment, “Standing and 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 Delegate Medical Director (or designee) after referral and medical documentation is received.

M. After approval of the standing specialty or extended access to specialty care with or without a treatment plan, Delegates are required to notify the PCP, specialist, and
14. UTILIZATION MANAGEMENT

C. Review Procedures
   2. Standing Referral/ Extended Access to Specialty Care

Member in writing of the specifics of the determination, within two (2) business days of the determination.

N. All denials of standing specialty referral requests or extended access to specialty care must be forwarded to IEHP within three (3) business days of the denial. Delegates must also inform the PCP, specialist, and Member of the denial in writing, according to prescribed formats for denials. Please refer to Policy 14A, “Utilization Management Delegation and Monitoring.”

O. Delegates can require specialists to provide, to the PCP and the Delegate, written reports of care provided under a standing referral.

Out of Network

A. Delegates are not required to refer Members to out-of-network practitioners unless appropriate specialty care is not available within the network.

B. Delegates must provide and coordinate any out-of-network services adequately and timely when such services are medically necessary and not available within the network.

C. Delegates 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.

D. Delegates are not required to refer Members to an out-of-network HIV/AIDS specialist unless an appropriate HIV/AIDS specialist, or qualified nurse practitioner, or physician assistant under the supervision of an HIV/AIDS specialist is not available within the network as determined by the Delegate in conjunction with IEHP’s Chief Medical Officer, as warranted.
14. UTILIZATION MANAGEMENT

D. Referral and Denial Audits

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. Per IEHP Policy 14A, “Utilization Management Delegation and Monitoring,” Utilization Management (UM) activities are delegated to contracted entities that meet IEHP UM standards.

B. IEHP performs monthly retrospective audit of denied and partially approved (modified) referrals submitted monthly by the Delegate.

C. IEHP performs monthly retrospective audit of approved referrals submitted monthly by the Delegate.

D. IEHP performs a Delegation Oversight Audit (DOA) of all Delegates to review the UM process for approving, denying or partially approving (modifying) referrals as outlined under Policy 14A, “Utilization Management Delegation and Monitoring.” Focused approved referral and denial audits are also performed when issues are identified.

DEFINITION:

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

PROCEDURES:

Monthly Retrospective Denial Audit

A. IEHP performs a monthly retrospective audit of denied and partially approved (modified) referrals submitted monthly by the Delegate.

B. IEHP uses the IPA Denial Log Review Tool for the monthly retrospective denial audits to evaluate referral timeliness and document the examined referral results.

C. In order to pass the monthly audit, the Delegates must achieve a:

1. Score of 90% or greater on:
   a. Overall Denial Review ;
   b. Critical Element #1: Member Notification;
   c. Critical Element #2: Member Language;
   d. Critical Element #3: Appropriate use of Criteria; and
14. UTILIZATION MANAGEMENT

D. Referral and Denial Audits

e. Critical Element #4: Correct Template.

2. Score of 5% or lesser on:
   a. Denial Rate
      1) Appropriateness and Volume of Denials would be taken into consideration

D. If the Delegate fails to achieve a Substantial Compliance score of 90% for two (2) consecutive months, on any of the audit areas above, a Corrective Action Plan (CAP) will be issued. At its discretion, IEHP may also enforce one (1) or more of the following:
   1. Concurrent denial review for a percentage of total denials may be initiated at which time the Delegate will receive a score of zero (0) for each month the concurrent review is conducted. IEHP will determine the percentage required for concurrent review;
   2. The Delegate may be frozen to new Member enrollment until the Delegate passes the monthly audit for two (2) consecutive months;
   3. A focused meeting with the Delegate’s Administration and IEHP’s Chief Network Officer, and/or Medical Director;
   4. Sanctions may be enforced as outlined in the Delegate’s contract with IEHP under Retrospective Denial Audits; and/or
   5. Other action as recommended by the Delegation Oversight Committee.

E. Persistent non-compliance may result in the termination of the Delegate’s contract.

Monthly Retrospective Approval Audit

A. IEHP performs a monthly retrospective audit of ten (10) approved referral files submitted monthly by the Delegate.

B. IEHP uses the IPA Approval Review Tool for the quarterly retrospective approval audits to evaluate referral timeliness and document the examined referral results.

C. In order to pass the quarterly audit, the Delegates must achieve a:
   1. Score of 90% or greater on the Overall Approval File Review

D. If the Delegate fails to achieve a Substantial Compliance score of 90% for one (1) quarter, a Corrective Action Plan (CAP) will be issued. At its discretion, IEHP may also enforce one or more of the following:
   1. Concurrent approval review for a percentage of total approvals may be initiated at which time the Delegate will receive a score of zero (0) for each month the concurrent review is conducted. IEHP will determine the percentage required for concurrent review;
14. UTILIZATION MANAGEMENT

D. Referral and Denial Audits

2. The Delegate may be frozen to new Member enrollment until the Delegate passes the monthly audit for two (2) consecutive months;

3. A focused meeting with the Delegate’s Administration and IEHP’s Chief Network Officer, and/or Medical Director; and

4. Other action as recommended by the Delegation Oversight Committee.

E. Persistent non-compliance may result in the termination of the Delegate’s contract.

Delegation Oversight Audit (DOA)

A. IEHP performs an onsite Delegation Oversight Audit DOA of all delegated entities to review the UM process. Please refer to Delegation Oversight Audit Preparation Instructions (See Attachment, “Delegation Oversight Audit Preparation Instructions” in Section 13).

B. IEHP staff notifies the Delegate in writing two (2) weeks in advance of the scheduled annual audit. IEHP reserves the right to give as little as twenty-four (24) hours verbal notice for focused audits that occur between DOAs.

C. Audit staff from IEHP includes, at a minimum, the Delegation Oversight Nurse. In addition, the IEHP Medical Director, Director of Quality Management, Quality Management Manager, or other IEHP staff may participate.

D. UM Process Review Components:
   1. Approved Referral File Review
      a. Approved pre-certification score will be based on the monthly file review. Delegate must submit ten (10) sample files with the monthly log.
   2. Denial File Review
      a. Denial File Review score will be an aggregate of the monthly retrospective denial audit scores for the period of July 1st of the previous calendar year through June 30th of the current year.

E. As part of the audit, IEHP requests details of the process used by the Delegate to follow-up and assure that Members receive approved services.

F. IEHP audit staff conducts a verbal exit conference with Delegate staff at the end of an audit.

G. Within thirty (30) days of the audit, a final score and cover letter are sent to the Delegate.

H. Delegates pass the UM Referral and Denial audit sections of the DOA if the following scores are achieved:
D. Referral and Denial Audits

1. 90% on the monthly aggregated Denial and Partially Approved (modifications) file review score for the period of July 1st of the previous calendar year through June 30th of the current year.

2. 90% on the quarterly aggregated Approval file review score for the period of July 1st of the previous calendar year through June 30th of the current year.

I. Delegates that score below 90% on the approved referral and/or denial and partial approval (modification) sections above are required to submit a CAP addressing all deficiencies noted at the audit within a specified timeframe. Delegates who disagree with the audit results can appeal through the IEHP Provider appeals process by submitting an appeal in writing to the IEHP Chief Medical Officer within sixty (60) calendar days after the release of the final audit results.

J. Delegates that score 90% or above may be required to submit a CAP to address any deficiencies.

K. Audit results are included in the overall annual assessment of Delegates.

Focused Audits

A. Focused audits are conducted under the following circumstances:

1. Follow-up audit for deficiencies noted on the DOA.

2. Review of approvals and denials demonstrate that decisions being made are inconsistent, do not appear to be medically appropriate, or are not based on professionally recognized standards of care.

3. Any other circumstance that in the judgment of the IEHP Chief Medical Officer requires a focused audit.

B. At the time of the focused audit, Delegates are instructed to produce thirty (30) approved and (30) denied including partially approved (modified) referrals along with their letter or other documentation that were provided the Member. If a Delegate has fewer than thirty (30) approved referrals and fewer than (30) denied including partially approved (modified) referrals, all of those referrals must be produced.

C. IEHP selects twenty (20) of the thirty (30) approved referrals and twenty (20) of the thirty (30) denied including partially approved (modified) referrals for review. If fewer than twenty (20) referrals are available, all referrals are reviewed.

D. If, during the focused audit, any of the selected referrals are deemed invalid by the reviewer (e.g., missing information or type of referral), the Delegate must substitute an alternate referral acceptable to IEHP.

E. IEHP uses the UM Approval Audit Tool for Focused Approved Referral Audits and the UM Denial Audit Tool for Focused Denied Referral Audits to document the examined referral results and evaluate referral timeliness.
F. If the Delegate fails to achieve a Substantial Compliance score of 90% for two (2) consecutive months of a Focused Audit, a CAP will be issued. At its discretion, IEHP may also enforce one (1) or more of the following:

1. Concurrent approval and denial review for a percentage of total approvals and denials may be initiated at which time the Delegate will receive a score of zero (0) for each month the concurrent review is conducted. IEHP will determine the percentage required for concurrent review.

2. The Delegate may be frozen to new Member enrollment until the Delegate passes the monthly Focused audit for two (2) consecutive months.

3. A focused meeting with the Delegate’s Administration and IEHP’s Chief Network Officer, and/or Medical Director.

4. Sanctions may be enforced as outlined in the Delegate’s contract with IEHP under Retrospective Approval and Denial Audits.

G. Persistent non-compliance may result in the termination of the Delegate’s contract.
14. UTILIZATION MANAGEMENT

E. Second Opinions

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. Primary Care Physicians (PCPs), Specialists, and Members (if the practitioner refuses), have the right to request a second opinion from their delegated entity, 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 assigned Delegate.

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.

DEFINITION:

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

PROCEDURES:

A. The Member’s request for a second opinion is processed through IEHP or their assigned Delegate’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 (800) 440-4347. IEHP’s Member Services staff directs the Member to an IEHP Care Manager. The Care Manager assists the Member in contacting his/her IPA to request a second opinion.

B. The PCP or specialist submits the request for a second opinion to the Delegate including documentation regarding the Member’s condition and proposed treatment.

C. If the referral for a second opinion is approved, the Delegate makes arrangements 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. If the referral is denied or partially approved (modified), the Delegate provides written notification to the Member, including rationale for the denial or partial approval (modification), alternative care recommendations, and information on how to appeal this
E. Second Opinions

decision. Request may be denied if Member insists on an out-of-network practitioner when there is an appropriately qualified practitioner in-network.

E. If there is no physician within the IEHP network that meets the qualifications for a second opinion, the Delegate 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. Delegates must provide and coordinate any out-of-network services adequately and timely.

G. Members disagreeing with their assigned Delegate’s denial of a second opinion may appeal through the IEHP Grievance process. Refer to Section 16, “Grievance 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 Medical Services reviews such requests, and if determined to be urgent, facilitates the process by working directly with the PCP and the Delegate. If determined by IEHP Medical Services to be not urgent, the Member is referred back to his/her PCP and assigned Delegate to continue the process.

J. The Delegate must utilize a Second Opinion Tracking Log (See Attachment, “Second Opinion Tracking Log” in Section 14) to track the status of second opinion requests and to ensure that the second opinion practitioner 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, by the 15th of the following month, to IEHP’s Quality Management (QM) department.

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
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E. Second Opinions

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 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 from his or her PCP, the second opinion must be provided by an appropriately qualified physician of the Member’s choice within the Delegate’s network.

M. If the Member is requesting a second opinion about care from a specialist, the second opinion must be provided by any physician of the same or equivalent specialty of the Member’s choice within the IEHP or the Delegate’s network. If the specialist is not within the Delegate’s network, IEHP incurs the cost of that second opinion. If not authorized, additional medical opinions obtained from a physician not within IEHP or the assigned Delegate’s network are the responsibility of the Member.

N. The Delegate is responsible for submitting a copy of all authorizations, partial approvals (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 provider portal within three (3) working days. BH Providers can receive training on how to use the 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, “Referral Tracking Log” in Section 14).
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E. Second Opinions

S. Mandated timeframes for decision including approval, denial or partial approval (modification) of a non-urgent or urgent or concurrent request for a second opinion and subsequent notification to the Member and Practitioner must follow the timeframes outlined in Policy 14A, “Utilization Management Delegation and Monitoring.”

T. If the referral is denied or partially approved, the Delegate provides written notification to the Member including rationale for the denial or partial approval, alternative care recommendations, and information on how to appeal this decision. The Member, Member’s Representatives, or practitioners appealing on behalf of the Member, may appeal a denial of a second opinion through the IEHP Grievance process.

U. IEHP’s Medical Director or physician designee or the Delegate’s Medical Director or physician designee may request a second opinion at any time it is felt to be necessary to support a proposed method of treatment or to provide recommendations for an alternative method of treatment.
14. UTILIZATION MANAGEMENT

F. Emergency Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal 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. Delegates are responsible for payment of professional services rendered to Members at the ED, per their contract with IEHP, and this policy. IEHP is responsible for the facility and technical services rendered to Members in the ED.

C. Per regulatory requirements, IEHP has adopted the “prudent layperson” definition of an emergency medical and psychiatric condition, as follows:

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; or
   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.

E. The financial responsibility associated with the diagnosis and/or treatment of a Member’s visit to an ED is as follows:
14. UTILIZATION MANAGEMENT

F. Emergency Services

1. Delegates are financially responsible for:
   a. All professional fees associated with the diagnosis and/or treatment of an ED visit when the Member has an emergency medical condition;
   b. All professional components of an ED visit authorized by a Primary Care Physician (PCP), Delegate, or IEHP designee regardless of whether the visit was emergent or non-emergent;
   c. The professional components of the MSE for non-authorized, non-emergent visits; and
   d. Facility components as per Delegate’s contractual agreement with IEHP.

2. IEHP is financially responsible for:
   a. All facility and technical fees when a Member has an emergency medical condition; and
   b. The facility and technical components of a MSE for non-authorized, non-emergent visits.

F. If it is determined that the Member’s condition was not emergent, the Delegate is responsible for the MSE, at a minimum. The Delegate is not required to notify the Member of an ED denial. 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 Delegate.

G. Emergency services can be subject to retrospective review by the Hospital or Delegate. Delegates may retrospectively review claims and adjust payment if services provided were beyond the scope of the authorization and were not medically necessary. A retrospective billing adjustment of an Emergency Department visit does not require Member notification because the Member is not financially impacted by the decision, and payment must be made for the MSE.

1. Hospitals can forward to the Delegate any facility costs associated with a visit to an ED that was authorized by a Delegate or PCP, and judged non-emergent after medical review by a hospital staff physician.

2. If medical review of the claim by the Delegate determines that the authorized visit was for a Member with a non-emergency medical condition, then the Delegate is financially responsible for the facility and technical components of the visit.

3. Where conflict regarding payment decisions cannot be resolved between hospital and Delegate, claims can be submitted to IEHP for final adjudication.

H. Delegates are encouraged to develop contractual arrangements with EDs and physician groups.
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F. Emergency Services

I. Delegates with contractual arrangements with EDs differing from the above policies and procedures regarding payment or services are subject to the above noted division of financial responsibility guidelines in the event of disputed claims appealed to IEHP.

J. Delegates shall make every effort to respond to requests for necessary post-stabilization medical care within thirty (30) minutes of receipt. In the event, the Delegate does not respond within the timeframe, the services are considered approved.

DEFINITION:

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

PROCEDURES:

A. Final determination of whether or not an emergency medical condition existed can be subject to medical review by a physician; however, the prudent layperson definition must be utilized in the review.

1. Medical decision criteria and diagnosis codes may be utilized in the review process; however, under the prudent layperson definition, the review must also take into account emergency medical conditions that present acutely but result in benign diagnoses. Examples include and are not limited to:
   a. 2-year old with 103° fever, listless, less responsive, vomiting - Otitis Media;
   b. 38-year old with acute, severe chest pain - Costochondritis;
   c. 17-year old female with severe lower abdominal pain, vaginal bleeding - Spontaneous Abortion - complete;
   d. 12-year old with severe shortness of breath, cough - Asthma;
   e. 60-year old with fever to 104°, severe cough, acute shortness of breath - Bronchitis;
   f. 23-year old pregnant woman with lower abdominal pain, fever, perceived decreased fetal movement - Urinary Tract Infection;
   g. 12-year old with severe abdominal pain, vomiting fever - Adenitis, Mesenteric; or
   h. Sudden onset of behavioral changes or an exacerbation of a known psychiatric diagnosis - Adjustment Disorder.

2. A physician must perform review of retrospective billing adjustments or reduction of payments of claims.
14. UTILIZATION MANAGEMENT

F. Emergency Services

B. 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. If the MSE demonstrates that an emergency medical condition is not present, ED personnel must contact the PCP, Delegate, or designee for authorization of services or treatment beyond the MSE.

C. The Delegate’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) CPT Guide under ‘Emergency Department Services.’

D. Authorized ED visits can be subject to review by IEHP to determine if an emergency medical condition was present. If medical review determines that an emergency medical condition was not present, the facility and technical components of the claim will be reviewed for payment. The Hospital can appeal adverse payment decisions for IEHP review.

E. Examples of non-emergent ED visits could include but are not limited to:
   1. Possible fractures (sprain – rule out fracture);
   2. Simple lacerations;
   3. Mild asthma exacerbation;
   4. Small animal bites; or
   5. High fever without systemic symptoms.
G. Pre-Service Referral Authorization Process

**APPLIES TO:**

A. This policy applies to all IEHP Medi-Cal 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 Delegate 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 Delegates must have a process in place to allow a specialist to directly request authorization from IEHP or the Delegate for additional specialty consultation, diagnostic, or therapeutic services.

D. IEHP and its Delegates must have a process in place when 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 Delegates should evaluate PCP and specialist referral patterns for over and under utilization.

**DEFINITION:**

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

**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;
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G. Pre-Service Referral Authorization Process

2. The diagnosis (ICD codes) 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.

C. Upon receipt of the referral, IEHP and its Delegates are responsible for verification of Member eligibility and plan benefits.

D. IEHP and its Delegates must have a process that facilitates the Member’s access to needed specialty care by prior authorizing, at a minimum, a consult and follow up visit (a total of two (2) 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 follow up visit, 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).
14. UTILIZATION MANAGEMENT

G. Pre-Service Referral Authorization Process

F. IEHP will accept only the listed request types for continued services from contracted DME vendors. Approval will be based on medical guidelines and frequency limitations.
   1. Home Oxygen and oxygen supplies must have oxygen saturation levels on room air annually.
   2. CPAP/BiPAP supplies
   3. Ostomy supplies
   4. Incontinent supplies
   5. Insulin pump supplies
   6. Enteral/Parenteral feeding pump supplies
   7. TENS unit supplies
   8. Suction canisters

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 Delegate. 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 notification of Members and practitioners (See Attachment, “UM Timeliness Standards – Medi-Cal” in Section 14). All timeframes must 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 Delegates 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 Delegate 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 Delegate, 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
14. UTILIZATION MANAGEMENT

G. Pre-Service Referral Authorization Process

the visit.

L. For the IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) 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. Members should be notified that their request has been forwarded to their Health Plan for determination.

REFERENCE:

A. 42 Code of Federal Regulations § 422.568, 422.570, 422.572, and 438.210
APPLIES TO:
A. This policy applies to all IEHP Medi-Cal Members.

POLICY:
A. The Delegate is responsible for authorizing all non-custom wheelchair purchases and wheelchair rentals.
B. IEHP requires a medical necessity evaluation for custom wheelchair requests. These evaluations will be performed by a physiatrist, orthopedist, neurologist, rheumatologist, or other qualified medical professional as authorized by the Delegate.
C. Custom wheelchair requests should be reviewed by the Delegate Medical Director. Requests that meet criteria are forwarded to IEHP for wheelchair purchase.
D. IEHP will arrange for 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 is responsible for repairs, maintenance, and rental of custom wheelchairs for qualified individuals.

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

PROCEDURES:
A. Prior to the submission of a request to IEHP for the purchase of a custom wheelchair, the Member must have an evaluation for medical necessity by a physiatrist, orthopedist, neurologist, or rheumatologist through the Delegate.
B. If the request for the purchase of a custom wheelchair based on the specialist evaluation meets criteria, the Delegate will forward the documentation to IEHP for determination.
C. The Delegate needs to submit the referral via fax with all supporting documentation to IEHP’s Utilization Management (UM) department no later than one (1) business day from the Delegate’s decision.
   1. The referral form must be faxed to IEHP’s UM department at (909) 890-5751 for review and coordination of services with a seating evaluation as applicable.
   2. Referral requests to IEHP for the purchase of a custom wheelchair must be accompanied at a minimum with the following:
      a. Completed referral form signed by the Member’s physician or specialist;
H. Wheelchair Purchase Referral Procedure

b. Information about the Member’s current equipment, if applicable; and

c. The medical necessity evaluation from the physiatrist or orthopedist.

D. IEHP’s UM department will review the referral and the supporting documentation and make a determination within timeframes as outlined in the UM Timeliness Standards from the receipt of the referral from the Delegate (See Attachment, “UM Timeliness Standards – Medi-Cal” in Section 14).

E. Notification will be provided to the Delegate, requesting Provider, PCP, and seating evaluator regarding the determination.

F. IEHP’s UM Department will send notification to the Delegate for care management and/or care coordination services.

G. IEHP 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 DME vendor, as needed.

J. IEHP is responsible for all repairs and maintenance of purchased custom wheelchairs. If a Delegate receives a request for such services, the referral must be faxed to the IEHP UM department at (909) 890-5751 within one (1) business day of receipt of the request.
14. UTILIZATION MANAGEMENT

I. Long Term Care (LTC) – Custodial Level

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. Long Term Care (LTC) facilities include skilled nursing, adult sub-acute, pediatric sub-acute, and other intermediate care units.

B. Members can be admitted to LTC facilities from acute inpatient settings, or transition from skilled level, or as direct admits from the community.

C. IEHP and/or IPAs are financially responsible for Medi-Cal Members requiring LTC facility admission. The IPA and IEHP financial responsibility for Medi-Cal Members under age 21 or residing in Intermediate Care Facilities for Developmentally Disabled (ICF-DD) continues until the date the Member is disenrolled from IEHP to Medi-Cal fee-for-service (FFS).

D. IPAs are responsible for notifying IEHP of Members who require admission to LTC facilities, as direct admits from the community and if the admission to LTC facility is after an acute inpatient admission.

E. IPAs are responsible for coordinating with IEHP the provision of all necessary care coordination for Members in LTC facilities.

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 for transition from the hospital.

B. To ensure all nursing facilities and subacute facilities comply with all regulatory guidelines.

PROCEDURES:

A. IEHP or the IPAs can admit and are responsible for determining the appropriate level of care for LTC facility placement of Members transitioned from an acute setting, or transitioning from skilled level with assistance from IPA CM, as needed.

B. Criteria for admission of Medi-Cal Members to various levels of LTC facilities are described in the following sections of Title 22 of the California Code of Regulations:
   1. Skilled Nursing Facility - Section 51124
   2. Sub-acute Level of Care - Section 51124.5
   3. Pediatric Sub-acute Care Services - Section 51124.6
14. UTILIZATION MANAGEMENT

I. Long Term Care (LTC) – Custodial Level

4. Intermediate Care Services - Section 51120

C. For direct admits from the community, the treating PCP or specialist must submit a referral to the Member’s assigned IPA requesting admission. IPAs are responsible for forwarding all requests for custodial level upon receipt to IEHP’s Utilization Management via fax at (909) 890-5751. IEHP or IPA CM is responsible to assist with coordination of all aspects of the admission including:

1. Determining the appropriate contracted facility for the Member;
2. Arranging any necessary transport services;
3. Arranging for physician coverage at the facility as needed; Arranging for any necessary transfer of medical information; and
4. If the IPA determines the need to keep the Member in their usual setting with additional ancillary services, then the IPA may contact IEHP’s Care Management Department.

D. Authorization details will be available for the facility view online once facility face sheet, admission orders, and if indicated, inter-facility transfer form, have been received by IEHP.

E. Concurrent review is performed until discharge. Concurrent review can be performed either on-site by chart review or telephonically. Facilities must submit an initial review for custodial level and then at least quarterly, unless directed otherwise by IEHP’s Case Manager (See Attachments, “Long Term Care (LTC) Initial Review Form” and “Long Term Care (LTC) Follow-Up Review Form” in Section 14).

F. IEHP or IPAs (IPA CM, and PCP) are responsible for the coordination of the Member’s medical needs while inpatient for the month of enrollment into the plan/IPA or admission to custodial care and month after, or until Member transfers into IEHP Direct.

G. IEHP or IPA must establish a length of stay estimate for the Member as soon as possible after admission. IPA will report all LTC facility admissions to IEHP if the anticipated stay is greater than the allotted benefit timeframe by faxing the LTC Data Sheet to (909) 477-8553 at time of admission (See Attachment, “Long Term Care (LTC) Data Sheet” in Section 14).

H. IEHP or IPAs are responsible for periodic evaluations to ascertain readiness for transition to a lower level of care such as assisted living, board and care facility, home with CBAS, or other alternative setting. Quarterly Minimum Data Set (MDS) may be used as review or evaluation if its completion time falls within the period the review/evaluation is due.

I. Financial responsibility for Members under age 21 and residing in ICF-DD facilities continues until the Member is disenrolled from IEHP to Medi-Cal FFS. IEHP will ensure that the Member is admitted to a contracted facility.

J. For Medi-Cal Members, IEHP and the Member’s assigned IPA CM are responsible for assessing whether a Member may be eligible for the Nursing Facility (NF) Waiver
14. UTILIZATION MANAGEMENT

I. Long Term Care (LTC) – Custodial Level

Program, in consultation with the Member’s family, as necessary. IEHP or IPA facilitates the application for the waiver for the NF program as outlined in Policy 12I4, “Home and Community Based Services (HCBS) - DHCS - Nursing Facility (NF) and Acute Hospital (AH) Waiver Program”. IPAs are financially responsible until the Member is accepted into the NF Program. If the Member is not accepted into the NF Waiver Program, the IPA and PCP remain responsible for all necessary care and CM until disenrolled to FFS (if Long Term Care continues).

K. Authorization will be given for bed hold as follows:
   1. The bed hold will be authorized for seven (7) days.
   2. A separate authorization will be issued for a seven (7) day bed hold.
   3. If the Member does not return to LTC facility who requested the hold in seven (7) 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.

L. IEHP will notify the Member thirty (30) days in advance of pending PCP change and/or IPA re-assignment, if the Member is expected to exceed month of admission and month following in LTC-Custodial Level. If the Member agrees to the PCP change and/or IPA re-assignment, Member remains in long term care at a custodial level, the IEHP Inpatient Coordinator will complete the request in IEHP’s system.

M. If the Member does not agree to the above changes, they will remain with their current PCP and/or IPA, The IPA will be notified.

N. Upon discharge from LTC, the Member will be reassigned to their original PCP and IPA.

O. Prior to ninety (90) days in LTC facility, the IEHP Inpatient Coordinator will request a copy of the completed MC171 form (if not already received) with the date it was submitted to the local agency (See Attachment, “MC171 Form and Instruction 15-07” in Section 14).

P. Authorization will be given for Leave of Absence (LOA).
   1. LOA will be authorized for up to eighteen (18) days per calendar year for non-developmentally disabled Members.
   2. Up to twelve (12) additional days of LOA may be approved per calendar year in increments of no more than two (2) consecutive days. The additional days of LOA must be in accordance with the Member’s care plan and appropriate to the mental and physical well-being of the Member.
   3. At least five (5) days of LTC inpatient care must be provided between each approved LOA.
14. UTILIZATION MANAGEMENT

I. Long Term Care (LTC) – Custodial Level

Q. When new Members residing in an out-of-area/out-of-network Skilled Nursing Facility (SNF) enroll into the health plan and proof of relationship has been established as outlined in Policy 12A6, “Care Management Requirements - Continuity of Care,” IEHP and the IPA shall offer the Member the opportunity to return to the out-of-area/out-of-network SNF after a medical necessary absence, such as a hospital admission. This does not apply to Members discharged from the SNF to the community or lower level of care.

REFERENCE:

A. 22 California Code of Regulations § 51124 et seq.
14. UTILIZATION MANAGEMENT

J. Long Term Care (LTC) - Skilled Level

APPLIES TO:

A. This policy applies for all IEHP Medi-Cal Members.

POLICY:

A. IEHP and IPAs delegated to perform Utilization Management (UM) activities except as otherwise noted.

B. IEHP is responsible for performing all aspects of non-delegated UM and Care Management (CM) related to LTC skilled level placement.

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 sub-acute facilities comply with all regulatory guidelines.

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 LTC’s 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 Member’s remaining in long term care from the prior month.

B. PCPs must evaluate a Member’s need for LTC skilled level placement. A referral request must be submitted with sufficient medical information from the Member’s PCP for review and recommendation when transitioning from a community or usual setting. 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/CM staff in lieu of a referral being generated.

C. IPAs are required to have a similar process for review and authorization of requests for LTC skilled level placements from home.

D. Prior to issuing verbal authorization for an admission, all the clinical reviews, discharge date, and discharge needs must be received from the facility with the exception of when a tracking number may be necessary prior to the admission/transfer for services such as
14. UTILIZATION MANAGEMENT

J. Long Term Care (LTC) - Skilled Level

long term acute care (LTAC), or long term care (LTC).

E. Authorization details will be available for the facility to view online 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 weekly unless directed otherwise by Long Term Care Review Nurse until discharge. Concurrent review may be performed either on-site by 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 twenty-four (24) 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; and

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 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 Forms” in Section 14).

8. Evaluation of alternative care to determine if the Member would be sufficient to achieve treatment goals, including:

a. Home health care;

b. LTC Long term/custodial care (based upon the Member’s benefit; see Policy 14I, “Long Term Care (LTC) – Custodial Level”);

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)” – formerly known as Adult Day Health Care (ADHC)); or child day care;
14. UTILIZATION MANAGEMENT

J. Long Term Care (LTC) - Skilled Level

e. Family education and training; and
f. Community networks and resources.

I. Appropriately licensed staff must assist in the evaluation and placement of Members into LTC’s 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 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. The IPAs Financial responsibility for professional services continues for the month of enrollment into the plan/IPA and admission and month following. Then the responsibility is transferred to the health plan if agreed upon by the Member.

O. The Medical Director or physician designee reviews all medical necessity denials. All denial 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 through electronic communication (e.g., phone or fax).

P. All stays greater than the month of admission and the month after become the responsibility of IEHP. IPAs are required to transfer the responsibility to IEHP’s Long Term Care (LTC) team if agreed upon by the Member.

Q. IEHP will notify the Member thirty (30) days in advance of any pending PCP and/or IPA re-assignment. If Member does not agree to the above changes, they will remain with their current PCP and/or IPA. The IPA will be notified.

R. Upon discharge from LTC, the Member will be reassigned to their original PCP and IPA.

S. IPAs must notify IEHP of Medi-Cal Members who are still in the facility on the 15th of the month using the LTC Data Sheet along with the face sheet to (909) 477-8553 (See Attachment, “Long Term Care (LTC) Data Sheet” in Section 14).

T. Authorization will be given for bed hold as follows:

1. The bed hold will be authorized for seven (7) days.
2. A separate authorization will be issued for a seven (7) days bed hold.
14. UTILIZATION MANAGEMENT

J. Long Term Care (LTC) - Skilled Level

3. If the Member does not return to LTC facility who requested the hold in seven (7) 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.

U. When new Members residing in an out-of-area/out-of-network Skilled Nursing Facility (SNF) enroll into the health plan and proof of relationship has been established as outlined in Policy 12A6, “Care Management Requirements - Continuity of Care,” IEHP and the IPA shall offer the Member the opportunity to return to the out-of-area/out-of-network SNF after a medical necessary absence, such as a hospital admission. This does not apply to Members discharged from the SNF to the community or lower level of care.
14. UTILIZATION MANAGEMENT

K. Hospice Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP and those IPAs delegated to perform Utilization Management (UM) activities except as otherwise noted.

B. IPAs delegated the responsibility of UM activities are accountable for authorizing, managing, and reporting hospice referrals to IEHP.

C. For non-delegated UM activities, IEHP UM and Care Management (CM) staff are responsible for assisting in the management of the Member’s care in the home environment.

D. Hospice services include the provision of palliative care and support services that focus on the Member and family’s physical and psychosocial needs.

E. Prior authorization is not required for hospice services except for inpatient admissions.

F. The only requirement for initiation of outpatient hospice care services is a physician’s certification that a Member has a terminal illness and a Member’s “election” of such services.

G. Home health and infusion services that are not a part of hospice services require prior authorization.

PROCEDURES:

A. IEHP and delegated IPAs must implement hospice services (per the Member’s benefit) to achieve the following objectives:

1. Meet the Member’s healthcare needs at home by utilizing contracted Providers and practitioners who provide hospice services;

2. Assist in the interdisciplinary team management and provision of the Member’s care in the most appropriate setting;

3. Provide services which maximize the Member’s potential to achieve an optimal state of health, ability to function, and comfort in the home environment; and

4. Promote cost-effective healthcare services by reducing the need for hospitalization or facility placement.

B. A designated Primary Care Physician (PCP) or specialist physician, if necessary, must have substantial involvement in the implementation of the home health, infusion, and hospice care management process.
14. UTILIZATION MANAGEMENT

K. Hospice Services

C. UM/CM staff must be qualified and appropriately licensed health professionals who are responsible for evaluating a Member’s illness, injury, degree of disability, and medical needs. UM/CM staff evaluate this information for appropriate and timely referral to hospice services and verify a Member’s eligibility and schedule of benefits.

1. The referring PCP or specialist must determine the medical necessity for hospice services.
   a. Prior authorization is required for an inpatient hospice.

2. Authorized services are coordinated with contracted vendors.

3. Extensions of service requests are authorized either through the delegated IPA or IEHP.

4. The requested services must be assessed for potential care management and referred as appropriate.

5. All interactions and care must be documented.

D. IEHP staff responsibilities include the following activities:

1. Assist in identifying Members who would benefit from hospice services, and work with the PCP to obtain written orders for medically indicated services, which includes identifying services that need to be provided on the day(s) the Provider does not show up, such as assistance with activities of daily living;

2. Verify the Member’s eligibility and benefits and only authorize medically appropriate services;

3. Utilize approved guidelines to determine the appropriateness of the referral to home health, infusion, or hospice services;

4. Assessing informal resources that may be available (e.g., family, neighbors, etc.) and when necessary, consulting with the county social services agencies or public authorities about available resources; and

5. Coordinate the referral with the PCP and obtain a signed physician’s order indicating the type and length of service required.

E. Services are authorized according to policy and procedure with appropriate notification to the PCP, vendor, and Member. All computer data entry is completed in the medical management system for tracking IEHP-authorized services. Authorizations are evaluated at a minimum of every thirty (30) days for any continued or extended request for services.

F. Arrangements are made for contracted Providers to carry out the treatment plan that involves skilled nursing, therapeutic services, and support services as appropriate.

G. UM/CM staff is involved in the management of the Member’s treatment plan and communicates progress and actions to the IPA or PCP. Staff monitors the Member’s
14. UTILIZATION MANAGEMENT

K. Hospice Services

discharge from service and follow-up care, as necessary.

H. All actions regarding the management of hospice services must be documented. Documentation includes treatment, the Member’s response to treatment, activities of daily living (ADL) issues, appointments, and any social concerns.

Hospice

A. Hospice care services include, but are not limited to the in accordance with DHCS All Plan Letter 13-014:

1. Nursing services;
2. Physical, occupational, or speech – language pathology;
3. Medical social services under the direction of the physician;
4. Home health aide and homemaker services;
5. Medical supplies and appliances;
6. Drugs and biologicals;
7. Physician services;
8. Counseling services related to the adjustment of the Member’s approaching death;
9. Continuous nursing services may be provided on a twenty-four (24)-hour basis only during period of crisis and only as necessary to maintain the terminally ill Member at home;
10. Respite care provided on an intermittent, non-routine, and occasional basis for up to five (5) consecutive days at a time;
11. Short term inpatient care for pain control or chronic symptom management, which cannot be managed in the home setting; and
12. Any other palliative item or service for which payment may otherwise be made under the medical program and that is included in the hospice plan of care.

B. Ongoing care coordination shall be provided to ensure that services necessary to diagnose, treat, and follow up on conditions not related to the terminal illness continue to be provided or are initiated as necessary.

C. Hospice care services are covered services and are not categorized as long term care services regardless of the Member’s expected or actual length of stay in a nursing facility while also receiving hospice care.

D. A Member (or authorized representative) must elect hospice care to receive it.

1. The election period shall consist of two (2) periods of ninety (90) days each; and
2. An unlimited number of subsequent periods of sixty (60) days each during the Member’s lifetime.
14. UTILIZATION MANAGEMENT

K. Hospice Services

E. (Medi-Cal only) (Cal. Code of Regulations, tit.22, § 51349) – Elections may be made for up to two (2) periods of ninety (90) days each, one (1) subsequent period of thirty (30) days, and one (1) one hundred eighty (180) day extension of the thirty (30) day period. Hospice services shall not be covered beyond three hundred ninety (390) days.

F. (Medi-Cal SPD Members under 21) (Social Security Act, Section 1905(o)(1)) – A voluntary election of hospice care for Members under 21 shall not constitute a waiver of any rights of that Member to be provided with, or to have payment made for covered services that are related to the treatment of that Member’s condition for which a diagnosis of terminal illness has been made.

G. If the Member elects an out-of-network (OON) hospice, the IPA or IEHP has the option of immediately initiating a contract (one time or ongoing) with the hospice Provider or referring the Member to a network hospice Provider.

1. In the following scenarios, IEHP or the IPA should consider a one time or ongoing contract with the established hospice Provider until the new election period, or until the end of hospice services:
   a. New Members receiving hospice at the time of their enrollment with IEHP may not be able to change their hospice Provider even if requested due to limitations on the number of times there may be a change in the designation of a hospice Provider during an election period.
   b. If it is determined that a change in hospice Providers would be disruptive to the Member’s care or would not be in the Member’s best interest.

REFERENCES:

A. 22 California Code of Regulations § 51349
B. Social Security Act § 1905(o)(1)
C. Department of Health Care Services (DHCS) All Plan Letter (APL) 13-014 supersedes APL 07-014, “Hospice Services and Medi-Cal Managed Care.”

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<th>INLAND EMPIRE HEALTH PLAN</th>
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<td>Chief Title: Chief of Medical Services</td>
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14. UTILIZATION MANAGEMENT

L. Acute Admission and Concurrent Review

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members.

POLICY:

A. Delegated entities are responsible to perform inpatient Utilization Management (UM) activities as outlined in their contract.

B. For those entities not delegated to perform inpatient Utilization Management activities, IEHP is responsible for inpatient concurrent review. The Delegate is responsible for notifying IEHP UM staff of any facility admissions.

PURPOSE:

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

DEFINITION:

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

PROCEDURES:

A. IEHP or Delegate is notified of all admissions by the hospital. Admission review is performed within one (1) business day of knowledge of admission.

1. IEHP or Delegate’s Inpatient UM department maintains a daily census in their Medical Management system to identify Members that have transitioned from one (1) setting to another setting.

B. No authorization number for an admission will be issued until all the clinical reviews, the discharge date, and discharge needs have been received from the facility. A tracking number may be necessary prior to the admission/transfer for services such as to long term acute care (LTAC), skilled nursing facility (SNF), or acute rehabilitation.

C. Concurrent review is performed until discharge. Concurrent review may be performed either on-site by chart review or telephonically; the frequency of which will be determined by IEHP or Delegate’s UM nurse for acute stays. Please refer to Policies 14I, “Long Term Care (LTC) – Custodial Level” and 14J, “Long Term Care (LTC) – Skilled Level” for review schedules specific to these levels of care.

D. 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.

E. Approved guidelines and criteria 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 coverage, and other factors that may impact the ability to implement an individual Member’s care plan.

F. Member eligibility and benefits are verified to ensure appropriate authorization and management of services.

G. 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.

H. Board certified physicians from appropriate specialty areas assist with determinations of medical appropriateness, as needed.

I. Either 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 the 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.

J. For denials of care or service, the practitioner must be initially notified within twenty-four (24) hours of the denial decision. Notification must be made to the practitioner, in writing, within twenty-four (24) hours of the request. The practitioner is instructed on how to request an expedited review at the time they are notified of a denial.

1. If the denial is either concurrent or post service (retrospective), and the Member is not at financial risk, the Member does not need to be notified.

2. 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.

K. Attending physician – The physician responsible for the Member’s care while hospitalized 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;
14. UTILIZATION MANAGEMENT

L. Acute Admission and Concurrent Review

3. Communicate the medical assessment to 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.

M. IEHP and Delegate’s UM/CM Staff are responsible for identifying and referring any potential quality of care issue occurring in an inpatient or outpatient setting to IEHP’s Quality Management (QM) Department. Indicators used for identification of potential quality of care issues 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).

N. Focused reviews are conducted for known problem diagnoses, procedures, or practitioners requiring guidance in managing the utilization of services.
## 14. UTILIZATION MANAGEMENT

### Attachments

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<td>UM Timeliness Standards – Medi-Cal</td>
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<Name>  
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RE: Request for Utilization Management (UM) Criteria  

Dear <Name>:  

Attached is the clinical guideline or criteria used for determining health care services specific for the procedure or condition requested.

The materials provided to you are guidelines used by the plan to authorize, modify, or deny services for Members with a similar illness or condition. Specific care and treatment may vary depending on individual needs and the benefits covered under your health plan.

Sincerely,

<Utilization Management Department>
## Inland Empire Health Plan

### Request for UM Criteria Log

**IPA Name:** ___________________________  **Log for Year:** ___________________________

| Date Requested | Date Sent | Sent via:  
F = fax  
EM = email  
GM = ground mail | Name of the Requesting Practitioner or Member | Member Name and IEHP ID # | Line of Business (MC, CMC) | Criteria Requested (i.e. InterQual-MRI Brain) | Reason for Request |
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### Legend:

- **F** = Fax  
- **MC** = Medi-Cal  
- **CMC** = IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)  
- **EM** = Email  
- **GM** = Ground
The Monthly Denial Listing must be submitted in Excel format.

### Legend:
- **Referral Type:**
  - Urgent
  - Routine
- **Decision Code:**
  - Denied
  - Modified
- **Reason Code:**
  - MN = Not Medically Necessary
  - NB = Non Benefit
  - OON = Out-of-Network
  - C-ALT = Care in Alternate Setting-C
  - CCS = California Children's Services
  - M-NSLC = Modified w/ NSLC
  - M-SLU = Modified w/ SLC
  - EXP = Experimental
- **Member Type:**
  - MC = Medi-Cal
  - HK = Healthy Kids
  - NS = Non-State
  - DC = DualChoice/Medicare

### Table:

<table>
<thead>
<tr>
<th>Member First Name</th>
<th>Member Last Name</th>
<th>IEHP ID#</th>
<th>DOB</th>
<th>Member SSN</th>
<th>Requesting Physician Name</th>
<th>Requesting Physician Specialty</th>
<th>Referral Type</th>
<th>Diagnosis Code &amp; Description</th>
<th>Procedure/Request Code &amp; Description</th>
<th>Request Date</th>
<th>Decision Date</th>
<th>Decision Code</th>
<th>Reason Code</th>
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Total # prior authorization requests (includes approved, modified & denied):

Total # denials and modifications:

**INLAND EMPIRE HEALTH PLAN**

MONTHLY DENIAL LISTING

Delegate Name: ___________________________  Date Submitted: ___________________________

Report for Month of: ___________________________  Submitted by: ___________________________
<table>
<thead>
<tr>
<th>QA: Proper letter template including attachments</th>
<th>QA: Criteria cited and type of denial coincides</th>
<th>QA: Member specific denial language</th>
<th>QA: Language cited in Member letter is understandable and at 6 grade reading level</th>
<th>QA: MED NEC DENIALS ONLY - # of documented attempt to obtain additional clinical info</th>
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</table>
## Referral Tracking Log

<table>
<thead>
<tr>
<th>Month:</th>
<th>LOB:</th>
<th>IPA:</th>
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<table>
<thead>
<tr>
<th>IPA Auth/Tracking number</th>
<th>Member Name</th>
<th>IEHP ID Number</th>
<th>Member DOB</th>
<th>Acuity of Referral*</th>
<th>Reason for Referral/DX</th>
<th>Service/Activity Requested</th>
<th>Date Rec'd from IPA</th>
<th>Requesting provider</th>
<th>Requested provider</th>
<th>Requested Prov Specialty</th>
<th>Referral decision**</th>
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*Acuity of Referral: Urgent or Routine

**Decision: Approved, Modified, or Denied
Standing Referral / Extended Access Referral to Specialty Care Request

Health Plan__________________________ 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 #__________________________

Eligibility Reviewed Thru________ Medi-Cal AEVS Confirmation #________________

Policy/Group #__________________________

Referral To (Physician Name):____________ Type of Specialist:____________

Phone #____________ FAX____________

Diagnosis Primary________________________________________________ ICD 10_________

Diagnosis Secondary________________________________________________ ICD 10_________

Practitioner Treatment Plan (Complete or attach)

<table>
<thead>
<tr>
<th># Visits/Period</th>
<th>Visits/3 Months</th>
<th>Visits/6 Months</th>
<th>Visits/9 Months</th>
<th>Visits/1 Year</th>
</tr>
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<tbody>
<tr>
<td>Time Requested  (fill in number of visits)</td>
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</table>
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 3 business days of receipt of the information.

**REVIEW COMMITTEE USE ONLY:**

- Does diagnosis meet the criteria of long term, life threatening, degenerative, disabling disease or complex medical condition?  Y _______ N _______.
- Is specialist in the plan network?  Y _______ N _______.

If out of network, is contract between plan and specialist obtained?  Y _______ N _______. Date___________.

# Visits/Period of Time:_____________________.

Date Medical Information Received: _______________________.

Approved Date: ____________. Modified Date: ____________. *Denied Date: ____________.

Authorized by ____________________________, M.D.
Medical Director or Designee

* If denied, indicate the reason for denial and alternatives suggested. Include this information in the denial letter.

Authorization #_________________. Date Valid From:_________. Thru:_____________________.

Decision made within 3 business days of receipt.  Y _______ N _______.

Notification Date:  To Requesting Practitioner_________________. By FAX_____. Letter_______.
To PCP_________________. By FAX_____. Letter_______.
To Specialist Consultant_________________. By FAX_____. Letter_______.
To Member_________________. By FAX_____. Letter_______.

Authorization remains valid only if Member is eligible.
Payment is contingent upon the patient’s eligibility at the time service is rendered.
### IPA Approval Review Tool

**All LOB's**

<table>
<thead>
<tr>
<th>(a) Approval Tracking #</th>
<th>(b) File Type requested</th>
<th>(c) Auto Authorization</th>
<th>(d) Referral Request Date</th>
<th>(e) Referral Received Date</th>
<th>(f) Decision Date</th>
<th>(g) Written Physician Notification Date</th>
<th>(h) Decision Time</th>
<th>(i) Member Written Notification Date</th>
<th>(j) Physician Written Notification Date</th>
<th>(k) Clinical Information</th>
<th>(l) Practitioner Language</th>
<th>(m) Clinical Information</th>
<th>(n) Referral Form</th>
<th>(o) Correct Template</th>
<th>(p) Points Received</th>
<th>(q) Points Possible</th>
<th>(r) Individual Score</th>
<th><strong>Comments</strong></th>
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**Selected Individual Scores:**

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**Total Score:** 0 80

### Data Dictionary

**Policy and/or Regulation**

- **a. Approval Tracking #**: The number located on the referral form for tracking purposes. Provided from the Delegate file submission.
- **b. File Type Requested**: Pre-Service Routine, Pre-Service Expedited, Post Service Retrospective Review. CMS UM Timeliness, IEHP Provider Policy and Procedure Medicare DualChoice 07/14 MA, 14A.8 - 10.
- **c. Auto Authorization**: Approvals that are instantly approved. CMS, IEHP Provider Policy and Procedure Medicare DualChoice 07/14 MA, 14A.15.
- **d. Referral Request Date**: Date the referral was sent to Delegate for review. CMS, IEHP Provider Policy and Procedure Medicare DualChoice 07/14 MA, 14A.9 - 11.
- **e. Referral Received Date**: Date the referral was received by the Delegate for a decision. CMS, IEHP Provider Policy and Procedure Medicare DualChoice 07/14 MA, 14A.14 - 15.
- **f. Decision Date**: Date the Delegate decision was made by the Delegate to Approve, Modify or Deny the case. CMS, IEHP Provider Policy and Procedure Medicare DualChoice 07/14 MA, 14A.9 - 11.
- **g. Written Physician Notification**: Date of the physician written notification. CMS UM Timeliness, IEHP Provider Policy and Procedure Medicare DualChoice 07/14 MA, 14A.8 - 10.
- **h. Decision Time**: Delegates decision to approve, modify, deny a referral request in a timely manner according to regulations. CMS, IEHP Provider Policy and Procedure Medicare DualChoice 07/14 MA, 14A.8 - 10.
- **i. Member Written Notification**: Written Notification to the Member of the requested referral decision by the Delegate. CMS, NCQA, IEHP Provider Policy and Procedure Medicare DualChoice 07/14 MA, 14A.8 - 10.
- **j. Physician Written Notification**: Written Notification to the physician of the requested referral decision by the Delegate. CMS, NCQA, IEHP Provider Policy and Procedure Medicare DualChoice 07/14 MA, 14A.8 - 10.
- **k. Member Language**: The approval letter Reason is clear & concise. CMS IEHP Provider Policy and Procedure Medicare DualChoice 07/14 MA, 14A.14.
- **l. Practitioner Language**: The approval letter reason is clear & concise. CMS, IEHP Provider Policy and Procedure Medicare DualChoice 07/14 MA, 14A.12.
- **m. Clinical Information**: Clinical information supporting the request. Not applicable if auto auth. CMS, IEHP Provider Policy and Procedure Medicare DualChoice 07/14 MA, 14A.12.
- **n. Referral Form**: Form submitted by Provider that includes requested services, CPT and ICD codes. CMS, IEHP Provider Policy and Procedure Medicare DualChoice 07/14 MA, 14A.14.
- **o. Correct Template**: Use of IEHP provided CMS Template. CMS, NCQA, IEHP Provider Policy and Procedure Medicare DualChoice 07/14 MA, 14A.8 - 10.
- **p. Points Received**: Total points earned from letters (g)-(r) above. N/A.
- **q. Points Possible**: Total points possible from letters (g)-(r) above, excluding non applicable elements. N/A.
- **r. Individual Score**: Total points earned from letters (g)-(r) above divided by total points possible from letters (g)-(r) above, excluding non applicable elements for each file. N/A.

Instructions: IEHP randomly selects # Approvals from delegates monthly universe submission. Each file will be reviewed using the elements below and noted as follows: “1” yes the information is present, “0” the information is not present, and a grayed out cell if the information is not applicable. Each file has a maximum score of 8.
**INLAND EMPIRE HEALTH PLAN**

**SECOND OPINION TRACKING LOG**

**IPA Name:** ___________________________  **Date Submitted:** ___________________________

**Report for Month of:** ___________________________  **Submitted by:** ___________________________

<table>
<thead>
<tr>
<th>Member Name and IEHP ID #</th>
<th>Name of the Requesting Practitioner or Member</th>
<th>Diagnosis</th>
<th>Reason for Second Opinion <em>(use codes below)</em></th>
<th>Request Date</th>
<th>Decision Date</th>
<th>Decision Code <em>(circle one)</em></th>
<th>Second Opinion to be provided by <em>(name):</em></th>
<th>Date of Appoint.</th>
<th>Date Consult Report Received</th>
<th>*See Legend Below For Member Type</th>
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**Second Opinion Reason Codes:**

- **Reason 1:** The Member questions the reasonableness or necessity of recommended surgical procedures.
- **Reason 2:** The Member questions a diagnosis or plan or 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.
- **Reason 3:** If 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 diagnosis.
- **Reason 4:** If 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 requests a second opinion regarding the diagnosis or continuance of the treatment.
- **Reason 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.

**Legend:**

- **MC** = Medi-Cal
- **NS** = Non-State
**SPECIALTY OFFICE SERVICE AUTHORIZATION SETS**

These procedures are to be performed in the office only. Specialty referral includes consult and one (1) follow-up visit unless otherwise noted and may include:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT Code</th>
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</thead>
<tbody>
<tr>
<td>Allergy - Skin Testing for 80 or Fewer Tests</td>
<td>95004 X up to 80</td>
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<tr>
<td>CARD – EKG (Adult &amp; Peds)</td>
<td>93000</td>
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<tr>
<td>CARD – Routine Stress Treadmill (Adult)</td>
<td>93015</td>
</tr>
<tr>
<td>CARD – Holter Monitor (Adult &amp; Peds)</td>
<td>93235</td>
</tr>
<tr>
<td>CARD – Echocardiogram (Peds only)</td>
<td>93303 or 93307 + 93320 + 93325</td>
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<tr>
<td>DERM – Punch Biopsy</td>
<td>11100</td>
</tr>
<tr>
<td>DERM – Cryotherapy of Lesions</td>
<td>17000, 17003, 17110</td>
</tr>
<tr>
<td>DERM – Excision of Nail &amp; Nail Matrix</td>
<td>11750</td>
</tr>
<tr>
<td>NEURO - EEG Standard</td>
<td>95816 or 95819</td>
</tr>
<tr>
<td>ENDO – Urinalysis</td>
<td>81003 or 82948</td>
</tr>
<tr>
<td>ENDO – Glucose/Blood</td>
<td>82947</td>
</tr>
<tr>
<td>ENDO – Fine Needle Aspiration of Thyroid</td>
<td>10021-10022</td>
</tr>
<tr>
<td>ENT – Tympanogram</td>
<td>92567</td>
</tr>
<tr>
<td>ENT – Pure Tone Audiogram</td>
<td>92557, 92582</td>
</tr>
<tr>
<td>ENT – Cerumen Removal</td>
<td>69210</td>
</tr>
<tr>
<td>ENT – Nasal Cauterization Treatment of Epistaxis (Anterior or Posterior)</td>
<td>30901,30905</td>
</tr>
<tr>
<td>ENT – Nasal Endoscopy</td>
<td>31231, 31238</td>
</tr>
<tr>
<td>ENT – Removal of Foreign Body Ear or Nose</td>
<td>69200, 30300</td>
</tr>
<tr>
<td>ENT – Streptococcus A Screen</td>
<td>87880</td>
</tr>
<tr>
<td>Gastroenterology – Flex Sigmoidoscopy</td>
<td>45330</td>
</tr>
<tr>
<td>GYN – Urine Pregnancy Test</td>
<td>81025</td>
</tr>
<tr>
<td>GYN – Depo-Provera</td>
<td>X6051</td>
</tr>
<tr>
<td>Procedure</td>
<td>CPT Code</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>GYN – Abnormal Pap Follow-Ups <em>and:</em></td>
<td>99213-99215 (X 3)</td>
</tr>
<tr>
<td>Colposcopy with Biopsy</td>
<td>57452 or 57454-455, 57460</td>
</tr>
<tr>
<td>Endometrial Biopsy</td>
<td>58100, 58558</td>
</tr>
<tr>
<td>LEEP</td>
<td>57460</td>
</tr>
<tr>
<td>Hematology - Bone Marrow Bx and/or Aspiration</td>
<td>38221, 38220</td>
</tr>
<tr>
<td>Hematology – Blood Smears</td>
<td>86007-85008</td>
</tr>
<tr>
<td>Nephrology – Urinalysis</td>
<td>8100-81003</td>
</tr>
<tr>
<td>Orthopedics – Total Fracture Care (Watch for CCS) X 6 mos.</td>
<td>By site of injury</td>
</tr>
<tr>
<td></td>
<td>By date of service</td>
</tr>
<tr>
<td>Orthopedics – X-Rays, in office simple extremity</td>
<td>73000-73140</td>
</tr>
<tr>
<td>Orthopedics – Casting, Splints</td>
<td></td>
</tr>
<tr>
<td>Orthopedics – DME (boot, shoe, crutches)</td>
<td></td>
</tr>
<tr>
<td>Orthopedics – Joint aspiration</td>
<td>20600-20615</td>
</tr>
<tr>
<td>Orthopedics – Trigger point injections</td>
<td></td>
</tr>
<tr>
<td>Injection of Tendon &amp; Ligament</td>
<td>20550-20553</td>
</tr>
<tr>
<td>Injection of Bursa</td>
<td>20600, 20605, 20610</td>
</tr>
<tr>
<td>Podiatry – Matrixectomy</td>
<td>11750</td>
</tr>
<tr>
<td>Podiatry – Debridement of Nails</td>
<td>11720-11721</td>
</tr>
<tr>
<td>Pulmonary – Spirometry</td>
<td>94010, 94060</td>
</tr>
<tr>
<td>Pulmonary – Blood Gases</td>
<td>82800-82810</td>
</tr>
<tr>
<td>Radiology - Mammogram</td>
<td>77057</td>
</tr>
<tr>
<td>- Breast Ultrasound @ radiologist suggestion</td>
<td>76645</td>
</tr>
<tr>
<td>- Cone View</td>
<td>77055</td>
</tr>
<tr>
<td>Rheumatology – T.P Injection</td>
<td>20552</td>
</tr>
<tr>
<td>Rheumatology – Injection of Tendon &amp; Ligament</td>
<td>20550-20553</td>
</tr>
<tr>
<td>Rheumatology – Joint Aspiration</td>
<td>20600-20615</td>
</tr>
<tr>
<td>Surgery – Breast Biopsy</td>
<td>77031</td>
</tr>
<tr>
<td>Surgery – I &amp; D of Cutaneous Abscess</td>
<td>10060-10061</td>
</tr>
<tr>
<td>Urology – Urinalysis</td>
<td>81000-81003</td>
</tr>
<tr>
<td>Urology - Cystoscopy</td>
<td>52000</td>
</tr>
</tbody>
</table>
This form is for services requiring health plan review.

### 1. Referrals

<table>
<thead>
<tr>
<th>Date: ________________________________</th>
<th>(TO BE COMPLETED BY IEHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXPEDITED - Decision w/in 72 hours</td>
<td>AUTH/TRACKING NUMBER:</td>
</tr>
<tr>
<td>ROUTINE</td>
<td>AUTH/EXPIRATION DATE:</td>
</tr>
<tr>
<td>PATIENT REQUESTED</td>
<td></td>
</tr>
<tr>
<td>RETRO</td>
<td></td>
</tr>
<tr>
<td>CBAS</td>
<td></td>
</tr>
</tbody>
</table>

#### 2. General Information

<table>
<thead>
<tr>
<th>Member Name (please print)</th>
<th>DOB</th>
<th>ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan (select one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medi-Cal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Kids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-State Programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open Access</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zip</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Diagnosis (Required)  

| 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.

### 3. Service Requested

<table>
<thead>
<tr>
<th>Service Requested (check one)</th>
<th>Consult</th>
<th>Follow-up</th>
<th>DME</th>
<th>Home Health</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location/Facility:</td>
<td>Office</td>
<td>Outpatient</td>
<td>Inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedure Requested (Submit supportive documentation with the claim to justify the Evaluation and Management (E &amp; M) code if this service will occur the same day as the procedure.)</td>
<td>CPT Code (REQUIRED)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Facility Address  

| Phone | Fax |

### 4. Completed By IEHP

<table>
<thead>
<tr>
<th>Date Additional Information Required:</th>
<th>Date Additional Information Received:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Approved</td>
</tr>
<tr>
<td></td>
<td>Modified</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

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.

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.

FAX COMPLETED REFERRAL FORMS TO (909) 890-5751
## Utilization Management Timeliness Standards
(Medi-Cal Managed Care - California)

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision</th>
<th>Initial Notification (Notification May Be Oral and/or Electronic)</th>
<th>Written/Electronic Notification of Denial and Modification to Practitioner and Member</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine (Non-urgent) Pre-Service</strong></td>
<td>Within 5 working days of receipt of all information reasonably necessary to render a decision</td>
<td>Practitioner: Within 24 hours of the decision</td>
<td>Practitioner: Within 2 working days of making the decision</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Member: None Specified</td>
<td>Member: Within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service</td>
</tr>
<tr>
<td><strong>Routine (Non-urgent) Pre-Service – Extension Needed</strong></td>
<td>Within 5 working days from receipt of the information reasonably necessary to render a decision but no longer than 14 calendar days from the receipt of the request</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Health Plan/Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Notify member and practitioner of decision to defer, in writing, within 5 working days of receipt of request &amp; provide 14 calendar days from the date of receipt of the original request for submission of requested information. Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Additional information received</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Practitioner: Within 24 hours of making the decision</td>
<td>Practitioner: Within 2 working days of making the decision</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Member: None Specified</td>
<td>Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service</td>
</tr>
</tbody>
</table>

Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s).
## Utilization Management Timeliness Standards
(Medi-Cal Managed Care - California)

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision</th>
<th>Notification Timeframe</th>
<th>Written/Electronic Notification of Denial and Modification to Practitioner and Member</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Notification</strong></td>
<td><strong>Practitioner:</strong> Within 24 hours of making the decision</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Member:</strong> None Specified</td>
<td></td>
<td><strong>Practitioner:</strong> Within 2 working days of making the decision</td>
</tr>
<tr>
<td></td>
<td><strong>Member:</strong> Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Additional information
- If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial.

#### Expedited Authorization (Pre-Service)
- Requests where provider indicates or the Provider Group/Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function.
- All necessary information received at time of initial request within 72 hours of receipt of the request.

#### Expedited Authorization (Pre-Service) - Extension Needed
- Requests where provider indicates or the Provider Group/Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function.

### Additional clinical information required:
- Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify practitioner and member using the “delay” form, and insert specifics about what has not been received, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered.

- Note: The time limit may be extended.

---

*ICE Medi-Cal UM TAT grid (California)*
*Final 8-10 rev. 11-04*
## Utilization Management Timeliness Standards
(Medi-Cal Managed Care - California)

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision</th>
<th>Notification Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>extended by up to 14 calendar days if the Member requests an extension, or if the Provider Group/Health Plan can provide justification upon request by the State for the need for additional information and how it is in the Member's interest</td>
<td>Practitioner: Within 24 hours of making the decision</td>
</tr>
<tr>
<td></td>
<td>Additional clinical information required</td>
<td>Member: None specified</td>
</tr>
<tr>
<td></td>
<td>Additional information received</td>
<td>Practitioner: Within 24 hours of making the decision</td>
</tr>
<tr>
<td></td>
<td>- If requested information is received, decision must be made within 1 working day of receipt of information.</td>
<td>Member: None specified</td>
</tr>
<tr>
<td></td>
<td>Additional information incomplete or not received</td>
<td>Practitioner: Within 24 hours of making the decision</td>
</tr>
<tr>
<td></td>
<td>- Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.</td>
<td>Member: None specified</td>
</tr>
<tr>
<td></td>
<td>Concurrent review of treatment regimen already in place—(i.e., inpatient, ongoing/ambulatory services)</td>
<td>Practitioner: Within 2 working days of making the decision</td>
</tr>
<tr>
<td></td>
<td>In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. CA H&amp;SC 1367.01 (h)(3)</td>
<td>Member: Within 2 working days of making the decision</td>
</tr>
<tr>
<td></td>
<td>Within 5 working days or less, consistent with urgency of Member's medical condition</td>
<td>Practitioner: Within 24 hours of making the decision</td>
</tr>
<tr>
<td></td>
<td>NOTE: When the enrollee's condition is such that the enrollee 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 the normal timeframe for the decision-making process… would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary</td>
<td>Member: None Specified</td>
</tr>
</tbody>
</table>

**Working day(s):** mean State calendar (State Appointment Calendar, Standard 101) working day(s).
### Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision</th>
<th>Initial Notification (Notification May Be Oral and/or Electronic)</th>
<th>Written/Electronic Notification of Denial and Modification to Practitioner and Member</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>and requested by the plan to make the determination CA H&amp;SC 1367.01 (h)(2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Concurrent</strong></td>
<td>Within 24 hours of receipt of the request</td>
<td>Practitioner: Within 24 hours of receipt of the request (for approvals and denials)</td>
<td>Member &amp; Practitioner: Within 24 hours of receipt of the request</td>
</tr>
<tr>
<td>review of treatment regimen already in place— (i.e., inpatient, ongoing/ambulatory services)</td>
<td>Member: Within 24 hours of receipt of the request (for approval decisions)</td>
<td>Note: If oral notification is given within 24 hour of request, then written/electronic notification must be given no later than 3 calendar days after the oral notification</td>
<td></td>
</tr>
<tr>
<td><strong>OPTIONAL</strong>: Health Plans that are NCQA accredited for Medi-Cal may chose to adhere to the more stringent NCQA standard for concurrent review as outlined.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Post-Service / Retrospective Review</strong> - All necessary information received at time of request (decision and notification is required within 30 calendar days from request)</td>
<td>Within 30 calendar days from receipt or request</td>
<td>Member &amp; Practitioner: None specified</td>
<td>Member &amp; Practitioner: Within 30 calendar days of receipt of the request</td>
</tr>
</tbody>
</table>

**Working day(s):** mean State calendar (State Appointment Calendar, Standard 101) working day(s).

ICE Medi-Cal UM TAT grid (California)
Final 8-10 rev. 11-04
<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision</th>
<th>Notification Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Post-Service</strong> - Extension Needed</td>
<td><strong>Additional clinical information required (AKA: deferral)</strong>&lt;br&gt;• Decision to defer must be made as soon as the Plan is aware that additional information is required to render a decision but no more than 30 days from the receipt of the request&lt;br&gt;<strong>Additional information received</strong>&lt;br&gt;• If requested information is received, decision must be made within 30 calendar days of receipt of information&lt;br&gt;Example: Total of X + 30 where X = number of days it takes to receive requested information</td>
<td><strong>Initial Notification (Notification May Be Oral and/or Electronic)</strong>&lt;br&gt;<strong>Member &amp; Practitioner:</strong> None specified&lt;br&gt;<strong>Written/Electronic Notification of Denial and Modification to Practitioner and Member</strong>&lt;br&gt;<strong>Member &amp; Practitioner:</strong> Within 30 calendar days from receipt of the information necessary to make the determination</td>
</tr>
<tr>
<td><strong>Additional information incomplete or not received</strong></td>
<td><strong>If information requested is incomplete or not received, decision must be made with the information that is available by the end of the 30th calendar day given to provide the information</strong></td>
<td><strong>Member &amp; Practitioner:</strong> None Required&lt;br&gt;<strong>Written/Electronic Notification of Denial and Modification to Practitioner and Member</strong>&lt;br&gt;<strong>Member &amp; Practitioner:</strong> Within 30 calendar days from receipt of the information necessary to make the determination</td>
</tr>
<tr>
<td><strong>Hospice - Inpatient Care</strong></td>
<td><strong>Within 24 hours of receipt of request</strong></td>
<td><strong>Practitioner:</strong> Within 24 hours of making the decision&lt;br&gt;<strong>Member:</strong> None Specified&lt;br&gt;<strong>Written/Electronic Notification of Denial and Modification to Practitioner and Member</strong>&lt;br&gt;<strong>Practitioner:</strong> Within 2 working days of making the decision&lt;br&gt;<strong>Member:</strong> Within 2 working days of making the decision</td>
</tr>
<tr>
<td>Member Name</td>
<td>Member ID</td>
<td>Facility Name</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------</td>
<td>---------------</td>
</tr>
</tbody>
</table>

*Legend:
BC = Board & Care
GH = Group Home
LA = Live Alone
AL = Assisted Living
HL = Homeless
SNF = Skilled Nursing Facility
LTC FOLLOW-UP REVIEW

Phone: 909-890-2054 / Fax: 909-477-8553

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

<table>
<thead>
<tr>
<th>Name (Last, First, M.I.)</th>
<th>DOB</th>
<th>Reference #</th>
<th>ID #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Activity Level</th>
<th>Height</th>
<th>Weight</th>
<th>DCP</th>
<th>LTC</th>
<th>B&amp;C</th>
<th>Home</th>
<th>Home with HH</th>
<th>Home with CBAS</th>
<th>Home with IHSS/hr/mo</th>
<th>#hrs/month</th>
</tr>
</thead>
</table>

- Cognitive Status Alert/Oriented:
  - [ ] x1
  - [ ] x2
  - [ ] x3
  - [ ] x4

- Criteria Met for Continued Stay:
  - [ ] Yes
  - [ ] No

  If yes, please describe deficit:

- Behavioral Change:
  - [ ] Yes
  - [ ] No

  If yes, please describe:

- Dietary Change:
  - [ ] Yes
  - [ ] No

  If yes, please describe:

- Medical Change:
  - [ ] Yes
  - [ ] No

  If yes, please describe:

- Medication Change:
  - [ ] Yes
  - [ ] No

  If yes, please describe:

- Skin Condition Change:
  - [ ] Yes
  - [ ] No

  If yes, please describe:

- Any Falls Since Last Review:
  - [ ] Yes
  - [ ] No

  If yes, please describe:

- Does SNF Facility Provide Transportation?:
  - [ ] Yes
  - [ ] No

  If no, please indicate needs:

<table>
<thead>
<tr>
<th>CONTINUED CARE NEEDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Care Needs (Check all conditions that apply):</td>
</tr>
<tr>
<td>□ Chemo</td>
</tr>
<tr>
<td>□ Eloper/Wanderer</td>
</tr>
<tr>
<td>□ Ileostomy</td>
</tr>
<tr>
<td>□ O2</td>
</tr>
<tr>
<td>□ Trach</td>
</tr>
<tr>
<td>□ Surgical</td>
</tr>
<tr>
<td>□ Pressure</td>
</tr>
<tr>
<td>□ Colostomy</td>
</tr>
<tr>
<td>□ Foley Cath</td>
</tr>
<tr>
<td>□ Isolation</td>
</tr>
<tr>
<td>□ Smoker</td>
</tr>
<tr>
<td>□ Other:</td>
</tr>
<tr>
<td>□ Arterial</td>
</tr>
<tr>
<td>□ Venous</td>
</tr>
<tr>
<td>□ Coma</td>
</tr>
<tr>
<td>□ G/J Tube</td>
</tr>
<tr>
<td>□ NG Tube</td>
</tr>
<tr>
<td>□ Radiation</td>
</tr>
<tr>
<td>□ Suctioning/Frequency:</td>
</tr>
<tr>
<td>□ Foot Wounds</td>
</tr>
<tr>
<td>□ Dialysis</td>
</tr>
<tr>
<td>□ HHN</td>
</tr>
<tr>
<td>□ NPO</td>
</tr>
<tr>
<td>□ TPN</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Mobility</td>
</tr>
<tr>
<td>□ Max</td>
</tr>
<tr>
<td>□ Mod</td>
</tr>
<tr>
<td>□ Min</td>
</tr>
<tr>
<td>□ Assist</td>
</tr>
<tr>
<td>□ Independent</td>
</tr>
<tr>
<td>Supine to Sit</td>
</tr>
<tr>
<td>□ Max</td>
</tr>
<tr>
<td>□ Mod</td>
</tr>
<tr>
<td>□ Min</td>
</tr>
<tr>
<td>□ Assist</td>
</tr>
<tr>
<td>□ Independent</td>
</tr>
<tr>
<td>Sit to Supine</td>
</tr>
<tr>
<td>□ Max</td>
</tr>
<tr>
<td>□ Mod</td>
</tr>
<tr>
<td>□ Min</td>
</tr>
<tr>
<td>□ Assist</td>
</tr>
<tr>
<td>□ Independent</td>
</tr>
</tbody>
</table>

- Indicate all appropriate assistive device(s) Member uses:
  - □ Wheelchair
  - □ Cane
  - □ Walker
  - □ Other

  - Gait Distance: x ft.
  - Wheelchair Mobility: x ft.
  - Safety/Balance: [ ] Good
  - [ ] Fair
  - [ ] Poor
  - Endurance: [ ] Good
  - [ ] Fair
  - [ ] Poor
  - Dressing Upper Body: □ Min
  - □ Mod
  - □ Max Assist
  - □ Independent
  - Dressing Lower Body: □ Min
  - □ Mod
  - □ Max Assist
  - □ Independent
  - Toileting: □ Min
  - □ Mod
  - □ Max Assist
  - □ Independent
  - Bathing: □ Min
  - □ Mod
  - □ Max Assist
  - □ Independent
  - Personal Hygiene: □ Min
  - □ Mod
  - □ Max Assist
  - □ Independent

<table>
<thead>
<tr>
<th>Treatment Goals Set:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Goals Met:</td>
</tr>
<tr>
<td>Comments/Other (e.g. Specialty Consultation):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Updates to Discharge Plan:</th>
</tr>
</thead>
</table>

| Date of Review | Nurse Reviewer Printed Name | Nurse Reviewer Signature | Contact Phone Number |
# LTC INITIAL REVIEW

Phone: 909-890-2054 / Fax: 909-477-8553

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

<table>
<thead>
<tr>
<th>Name (Last, First, M.I.)</th>
<th>DOB</th>
<th>Reference #</th>
<th>ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admit Dx:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-Morbidities:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admit Level of Care:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Justification for Level:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DCP:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Goals:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Training Goals:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does Member Have an Advance Directive or Living Will?</td>
<td>Yes</td>
<td>No</td>
<td>DPOA:</td>
</tr>
<tr>
<td>Does SNF Facility Provide Transportation?</td>
<td>Yes</td>
<td>No</td>
<td>Other:</td>
</tr>
<tr>
<td>Indicate Transportation Needs:</td>
<td>O₂</td>
<td>Cane</td>
<td>Gurney</td>
</tr>
</tbody>
</table>

## PATIENT SUPPORT/ CAREGIVER

<table>
<thead>
<tr>
<th>Name (Last, First, M.I.)</th>
<th>Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Email:</td>
</tr>
<tr>
<td>Party to Sign Contract:</td>
<td></td>
</tr>
<tr>
<td>Home Number:</td>
<td>Cell Number:</td>
</tr>
<tr>
<td></td>
<td>Work Number:</td>
</tr>
</tbody>
</table>

## PERSONAL SAFETY & ACTIVITY LEVEL

<table>
<thead>
<tr>
<th>Resident Care Needs</th>
<th>Dietary Requirements/ Restrictions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Chemo</td>
<td>□ Eloper/Wanderer</td>
</tr>
<tr>
<td>□ Colostomy</td>
<td>□ Foley Cath</td>
</tr>
<tr>
<td>□ Coma</td>
<td>□ G/J Tube</td>
</tr>
<tr>
<td>□ Dialysis/Days</td>
<td>□ H/HN</td>
</tr>
<tr>
<td>□ Dialysis/Days</td>
<td>□ NPO</td>
</tr>
<tr>
<td>□ Dialysis/Days</td>
<td>□ TPN</td>
</tr>
</tbody>
</table>

**Dietary Requirements/ Restrictions:**
- □ Chemo
- □ Eloper/Wanderer
- □ Ileostomy
- □ O₂
- □ Trach
- □ Surgical
- □ Arterial
- □ Pressure
- □ Venous Stage(s):
- □ Wounds
- □ Other:
- □ Surgical
- □ Arterial
- □ Pressure
- □ Venous Stage(s):
- □ Wounds
- □ Other:
- □ Surgical
- □ Arterial
- □ Pressure
- □ Venous Stage(s):
- □ Wounds
- □ Other:
- □ Surgical
- □ Arterial
- □ Pressure
- □ Venous Stage(s):
- □ Wounds

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

**Prior Level of Functioning:**

**Current Level of Functioning:**

**Discharge Plan:**

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

<table>
<thead>
<tr>
<th>Name the Drug(s):</th>
<th>Strength:</th>
<th>Frequency Taken:</th>
</tr>
</thead>
</table>

Date of Review Nurse Reviewer Printed Name Nurse Reviewer Signature Contact Phone Number
**I. COMPLETE THIS PORTION FOR ALL ACTIONS**

<table>
<thead>
<tr>
<th>Patient’s name (last) (first) (MI)</th>
<th>Name of facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social security number</td>
<td>Address (number and street)</td>
</tr>
</tbody>
</table>

Note: Level of care is SNF/ICF unless checked here as board and care.

| City | State | ZIP code |

**II. COMPLETE THIS PORTION ONLY FOR ADMISSIONS**

<table>
<thead>
<tr>
<th>Medi-Cal ID number (taken from the Medi-Cal card)</th>
<th>Admission date (month/day/year)</th>
</tr>
</thead>
</table>

A. Do you have Medicare Part A, Hospital Coverage?
   - [ ] Yes
   - [ ] No

B. Expected length of stay:
   - [ ] At least one full month after the month of admission
   - [ ] Less than one full month after the month of admission

C. Medi-Cal is expected to pay over 50% of facility cost of care.
   - [ ] Yes, beginning with month of ______, 20__
   - [ ] No, other insurance, private pay, etc.

D. Current income (check all applicable boxes):
   - [ ] Supplemental Security Gold Checks
   - [ ] Social Security Green Checks
   - [ ] Other Income (i.e., railroad, military retirement, etc.)
   - [ ] None

E. Admission from:
   - [ ] Home
   - [ ] Board and Care
   - [ ] Household of another
   - [ ] Acute Hospital—Home, B&C, other household immediately prior to acute
   - [ ] Acute Hospital—SNF/ICF immediately prior to acute
   - [ ] Acute Hospital extended stay—over 30 days
   - [ ] Another SNF/ICF

F. If known, enter your address prior to facility admission. If admitted from an acute hospital, enter your address prior to the acute hospital admission. (Do not give the acute hospital’s address.)

| Address (number and street) | City | State | ZIP code |

G. Signature of recipient or representative payee or family member/other:

| Signature of recipient | Signature of Representative Payee | Phone number |

If recipient’s signature cannot be obtained, please indicate reason in this space.

| Signature of family member/other (Indicate your relationship to the recipient.) | Phone number |

**III. COMPLETE THIS PORTION ONLY FOR DISCHARGES**

A. Reason for discharge:
   - [ ] Discharged to Acute Hospital
   - [ ] Discharged to another SNF/ICF
   - [ ] Discharged to residence/home of another
   - [ ] Discharged to Board and Care
   - [ ] Discharged to other
   - [ ] Discharge due to death

B. Date of discharge (month/day/year)

C. Medi-Cal ID number (taken from the Medi-Cal card)

D. Complete the forwarding address for discharges other than death:

<table>
<thead>
<tr>
<th>Name of facility (if not discharged home)</th>
<th>Address (number and street)</th>
</tr>
</thead>
</table>

| City | State | ZIP code |

Facility representative signature

| Date |

MC 171 (05/07)
I. General Instructions

This form is to be used for each admission and discharge. Please do not use this form for Medi-Cal reauthorizations.

II. Admission Instructions

A. Preparation

Prepare an original and two copies of this form for each SSI/SSP and/or Medi-Cal admission.

B. Distribution

Original: Send to your local social security office for recipients with aid codes 10, 20, and 60. Send to the county welfare department (see attached list) for all other aid codes.

Copy 1: Attach to the Treatment Authorization Request (TAR) and send to the Department of Care Health Services, Medi-Cal field office in your area. It will be forwarded by the Medi-Cal field office to the county welfare department.

Copy 2: Retain for your file.

III. Discharge Instructions

A. Preparation

Prepare an original and two copies of this form for each SSI/SSP and/or Medi-Cal discharge. Instead of completing a new form, use copy two of the form retained in your file as part of the admissions process. Complete Part III of the form (which becomes the original for the discharge process), and make two copies.

B. Distribution

Original: Send to the Medi-Cal field office.

Copy 1: Send to the county welfare department (see attached list).

Copy 2: Retain for your file.

IV. Explanation of over 50% of cost of care mentioned in item II.C. of this form.

Cost of care is the daily charge per patient excluding any additional services rendered to the patient which are billed separately by other providers (i.e., ambulance, physician, pharmacy, etc.).

For example, if the daily rate is $30 per day, the monthly charge for a 30-day month would be $900. If a patient enters the facility during the month of January, and is expected to stay at least one full calendar month after the month of admission (through February), a “YES” response would be indicated for item II.C. if Medi-Cal is expected to pay over $450 of the $900 charge for February.
### Med-Cal Index of Supplies

**Inland Empire Health Plan**  
Medi-Cal Index of Supplies  
Hosp = Capitated to Hospital  
IPA = Capitated to IPA  
Rx = Pharmacy

<table>
<thead>
<tr>
<th>ITEM</th>
<th>HOSP</th>
<th>IPA</th>
<th>RX</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetest Tablets</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aero Chamber</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzoin, Tincture</td>
<td>x</td>
<td></td>
<td>For Trach/Ostomy Care</td>
<td></td>
</tr>
<tr>
<td><strong>Catheter Supplies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foley, Straight, Retention Bags (Leg &amp; Standard Drainage) Clamps Insertion Tray Suction Type Irrigation Kits</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>Hospital responsibility if provided in the hospital. All others are IPA responsibility.</td>
</tr>
<tr>
<td>Clinitest Analysis Kit</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinitest Tablets</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dextrostix</td>
<td>x</td>
<td></td>
<td>Diabetic supply</td>
<td></td>
</tr>
<tr>
<td>Diastix</td>
<td>x</td>
<td></td>
<td>Diabetic supply</td>
<td></td>
</tr>
<tr>
<td>Fistula Supplies</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Keto-Diastix</td>
<td>x</td>
<td></td>
<td>Diabetic supply</td>
<td></td>
</tr>
<tr>
<td>Ketostix Strips</td>
<td>x</td>
<td></td>
<td>Diabetic supply</td>
<td></td>
</tr>
<tr>
<td><strong>Ostomy Supplies (Colostomy, Ileostomy, Ureteroostomy)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 x 4’s adhesive remover, bags, bag deodorant, belts, clamps connectors, adhesive disc (dressing or gasket), skin barriers, skin cleansers, tape and Tincture of Benzoin. Irrigation sets Adhesive Removers Collyseals Coloplast Karaya Products: Gaskets, Powder, Spray, Rings and Wafers</td>
<td>x</td>
<td></td>
<td>x</td>
<td>Hospital responsibility if inpatient. Others are IPA responsibility. Only bag deodorant or skin cleaners are covered when used for colostomy/ostomy patients. Regular deodorants, body lotions, protective ointments, emollients and moisturizers and shampoos are not covered.</td>
</tr>
<tr>
<td>Suspensories (Vaginal)</td>
<td>x</td>
<td></td>
<td></td>
<td>Used for suspension of vagina</td>
</tr>
<tr>
<td><strong>Tracheostomy Supplies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bibs, cleaning kits, cuffs, dressings, irrigation equipment, plugs, suction catheters, ties (twill tape), tubes, and</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All DME, Corrective Appliances and Prosthetics and Orthotics must be approved by the Food and Drug Administration (FDA) and be generally considered safe and effective for the purpose intended; and reasonable and medically necessary for the individual patient.
All DME, Corrective Appliances and Prosthetics and Orthotics must be approved by the Food and Drug Administration (FDA) and be generally considered safe and effective for the purpose intended; and reasonable and medically necessary for the individual patient.
### OPTIONAL BENEFITS GRID

The purpose of the following grid is to ensure uniformity across the health plan regarding the adjudication of authorization requests for eliminated and/or optional Medi-Cal benefits for **adults**. This grid should also serve as a guide for those services that may be approved for medical necessity. Please bear in mind that for Medi-Cal, the law considers a beneficiary an adult on their **21st birthday**. Medi-Cal beneficiaries who are not yet 21 continue to have the optional benefits covered.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Covered for Medical Necessity</th>
<th>No longer covered</th>
</tr>
</thead>
</table>
| Optometry*       | 1. Routine eye exams once every 24 months.  
2. Diabetic retinal exams.                                                                  | Optometry – glasses/contacts and TPA services **will not be covered** for our adult Medi-Cal Members                      |
| Podiatry         | 1. Medically necessary foot care for diabetics or other illnesses may be covered on a case by case basis.  
(Matrixectomy should be covered along with any conditions that may lead to hospitalization if lower level care is not rendered.)  
2. Orthotics are covered when medically necessary.  
3. All Medi-Cal podiatric services are covered when provided by Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs). | Podiatry – routine podiatry services  
- Routine nail trimming without evidence of a disease process.  
- Bunions, plantar fasciitis consults when no conservative therapy has been attempted.  
IEHP may restrict reimbursement to contracted FQHC/RHC providers, except as required by current out-of-network provider services policies. |
| Speech Therapy   | Speech Therapy – medically necessary services may be covered on a case by case basis, e.g., swallowing evaluation or speech therapy for a post-stroke patient |                                                                                                                                 |
| Incontinence     | Incontinence Creams and Washes – will be covered.                                              |                                                                                                                                 |
| therapies        |                                                                                                                                 |
| Audiology        | Medically necessary services may be covered on a case by case basis. Hearing aids are **still a benefit** and an audiogram is required to verify that the hearing loss is significant enough to justify the device. |                                                                                                                                 |
Denial Language for specific Non-covered cases:

Optometry
IEHP covers Optometry services for Members who are diabetic (high blood sugar) and need an annual diabetic eye exam to rule out diabetic retinopathy (damage to the retina, caused by complications of diabetes mellitus, which can eventually lead to blindness).

The medical information received from your doctor does not indicate you are a diabetic (a condition that causes high blood sugar levels in the blood).

Please follow-up with your doctor for additional treatment options.

*Routine optometry services for adults (21 and older) were reinstated in July 2010, retroactive to July 1, 2009.

Podiatry
IEHP covers all medically necessary foot care and Podiatry (specialist in the treatment of disorders of the foot) services for Members who are diabetic (a condition that causes high blood sugar levels in the blood) and need diabetic foot care, or for removal of ingrown toenail. IEHP also covers all Podiatry services that are provided by contracted Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs). Podiatry services for adults (21 and over) having diagnosis other than these is not a covered benefit under Medi-Cal or IEHP. The medical information received from your doctor does not indicate you are diabetic, or have an ingrown nail.

Please follow-up with your doctor for additional treatment options.