A. Utilization Management Delegation and Monitoring

APPLIES TO:

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

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 contracted 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), Department of Managed Health Care (DMHC), and Centers for Medicare and Medicaid (CMS) standards.

F. Practitioners and Delegate employees/staff who make utilization-related decisions are responsible for identifying barriers to care, 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 a tracking mechanism for these requests.

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

J. 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.
14. UTILIZATION MANAGEMENT

A. Utilization Management Delegation and Monitoring

**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. These standards represent the minimum performance level acceptable to IEHP.

B. **Criteria:** Nationally recognized Clinical Criteria must be used when making decisions related to medical care. Only these IEHP-approved criteria sets may be used: Centers for Medicare and Medicaid Services (CMS) Local Coverage Determination and National Coverage Determination, IEHP UM Subcommittee Approved Authorization Guidelines, Milliman Care Guidelines, InterQual, and Apollo Managed Care Guidelines/Medical Review Criteria.

1. **Development:** Criteria or guidelines that are developed by IEHP and used to determine whether to authorize, 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:** Criteria must be applied in a consistent and appropriate manner based on available medical information and the needs of individual Members. To ensure consistent application of UM Criteria follow this specific order as the Delegate is licensed to use:
   a. Check CMS guideline in this order:
      1) Local Coverage Determination;
      2) National Coverage Determination;
   b. Check if there is an approved IEHP UM Subcommittee guideline to reference and note the most current adopted date;
   c. Check Milliman Care Guidelines;
   d. Check InterQual;
   e. Check Apollo Medical Review Criteria.

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
14. UTILIZATION MANAGEMENT

A. Utilization Management Delegation and Monitoring

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 or home care, CBAS, IHSS, MLTSS, MSSP, or Behavioral Health; and

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

3. Criteria are presented to the UM Subcommittee for adoption and implementation, after approval by UM Subcommittee it is sent to QM Committee for final approval.

4. 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 or QM Committee has approved the criteria and updates, the information is disseminated to Providers via letter, website, email, or site visits.

5. Process for Obtaining Criteria: The clinical guidelines or criteria used for determining health care services specific to the procedure or condition must be disclosed to network practitioners, Members, or the public, upon request.

IEHP or 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 online.

Member letters must state the address, toll free phone number, 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”. A log must be maintained of all requests for criteria (See Attachment, “Request for UM Criteria Log” in Section 14). UM staff must be available during normal business hours, Monday through Friday, 8:00 AM to 5:00 PM to answer any UM issues.
6. **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 of the following three (3) auditing methods (5 percent or fifty (50) of its UM determination files, whichever is less, NCQA 8/30 methodology, or ten (10) hypothetical cases).

7. **Behavioral Health Triage and Referral:** The IEHP Behavioral Health Program 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.
   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. IEHP DualChoice Members shall access behavioral health services through IEHP’s network of Behavioral Health Providers. Members under the care of a county mental health Provider may continue to receive services through the county. Members can receive services in either county regardless of their county of residence. PCPs or IPAs will refer Members for behavioral health services to the IEHP Behavioral Health Unit for triage and referral to an IEHP Behavioral Health Provider by using the “PCP Referral to Behavioral Health Specialist” web form available at [www.iehp.org](http://www.iehp.org). Urgent or Emergent behavioral health referrals must be “warm transferred” to the IEHP Behavioral Health unit by calling (909) 890-2362.

1. **Delegate UM Structure:** 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 behavioral health needs. The UM Program must be evaluated, and updated if necessary, at least annually.
14. UTILIZATION MANAGEMENT

A. Utilization Management Delegation and Monitoring

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.

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 modified for medical necessity or benefit coverage;

b. Review of modified or denied referrals to assure consistent process 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, 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.

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;
14. UTILIZATION MANAGEMENT

A. Utilization Management Delegation and Monitoring

c. Authorization process, in detail, including staffing and 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 and regulatory standards;
i. Denial process that includes letters to Members and practitioners;
j. Procedures for informing practitioners of referral process; and
k. Dissemination of summary 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; or
   b. Following the Health Plan’s 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.
   b. RN/LVN – initial review of medical information, initial determination of benefit coverage, obtaining additional medical information, as needed, from the practitioner’s office, approval of medically routine referrals, preliminary denial for eligibility.
   c. A physician must supervise review processes and decisions.
   d. A designated California licensed physician (with an unrestricted license) must review all the 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.
A. Utilization Management Delegation and Monitoring

- 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, 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 PCPs and IEHP, if requested.

2. **Use of Board Certified Physicians for UM Decisions**: IEHP and 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 a 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 (1) or more external review companies, for specialty consultation.

E. **Authorization, Inpatient Review, and Notification Standards**: There must be written policies and procedures regarding the process to review, approve, modify or deny prospective, concurrent, or retrospective requests by Providers or practitioners concerning the provision of health care services for Members. These policies and procedures must be available to the public upon request. See Policy 11B, “Exception Requests for Formulary and Non-Formulary Drug,” for further details regarding pharmaceutical pre-authorization guidelines.

1. **Communication Services**: There must be access to staff for Members and practitioners seeking information about the UM Process and the authorization of care. This includes the following:

   - a. 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, specialists’ 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, and to ensure coordination of medically necessary care from the non-network specialist. 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 through IEHP or as per Delegate’s contract.

a. Prior Authorization of Non-urgent Pre-Service Organization Determinations:

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 emergency care.

2) The timeframes for completion and adjudication of the referral are as follows:

- **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 phone number and fax number to the referring physician for any questions or communication regarding the referral.

- The decision to approve, modify, or deny, must be made according to industry standards. For more information, please see Policy 14E, "Pre-Service Referral Authorization Process". For Members with Dual coverage, the primary insurance will determine the decision time frame. (See
A. Utilization Management Delegation and Monitoring


Delegate will identify upon intake any prior authorization request in which the Health Plan is responsible for making a determination (including requests for non-emergent medical transportation, behavioral health, optometry and general anesthesia for routine dental requests) and will ensure this request is forwarded to the health plan within twenty-four (24) hours of receipt by uploading requests via IEHP’s Secure File Transfer Portal (SFTP) site, into the ‘Health Plan Review’ folder. IEHP conducts a daily sweep for files uploaded to the ‘Health Plan Review’ folder.

The timeframe begins from receipt of the request. If information necessary to make a determination is not available with the referral, the requesting practitioner must be contacted preferably by telephone for the additional clinical information. The request for additional information must be annotated and must include the date of the request.

- All referrals should be processed as expeditiously as the Member’s health condition dictates, based on the reviewer’s clinical judgment.

- Members and Practitioners must be initially notified within fourteen (14) calendar days of receipt of request electronically or telephonically. Telephonic communications of decisions must be documented including date, time, name of contact person, and initials of person making the call, with each attempt.

- Both the Member and practitioner must be notified in writing, of all decisions within fourteen (14) calendar days of receipt of request.


1) Urgent/EIOD pre-service decisions are required if:

- 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
14. UTILIZATION MANAGEMENT

A. Utilization Management Delegation and Monitoring

2) Prior authorization is not required for services necessary to treat and stabilize an emergency medical condition. Please see Policy 14D, "Emergency Services," for more information.

3) The Member, Member designee or the practitioner on behalf of the Member may initiate an EIOD.

4) Practitioners must submit urgent referrals the same day of the determination that the referral is necessary. Decisions to approve, modify, or deny regarding prior authorization must be made according to industry standards (See Attachment, “UM Timeliness Standards – IEHP DualChoice” in Section 14).

5) The timeframe begins from the time and date the request is received. 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 preferably by telephone at least two (2) times and if deemed necessary by a Medical Director. The request for additional information must be annotated and must include the date of the request.

6) Members and Practitioners must be initially notified within seventy-two (72) hours after receipt of request. Telephonic communications of decisions must be documented including date, time, name of contact person, and initials of person making the call, with each attempt.

7) Both the Member and practitioner must be notified of all decisions 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.

8) The Delegate must notify both the practitioner and Member utilizing the IEHP approved “Integrated Denial Notice” template 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/mmp/.
A. Utilization Management Delegation and Monitoring

c. Post-Service Organization Determinations (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 (30) thirty 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 (being dual eligible), 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, “UM Timeliness Standards – IEHP DualChoice” 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 Member letter.
A. Utilization Management Delegation and Monitoring

e. **Denial Notices**: Any denial, in whole or in part, of a requested health care service must be reviewed and approved by the UM Medical Director, physician designee, or UM Committee. Members must receive an approved Integrated Denial Notice (IDN) letter for any requested referral that is denied or partially approved (modified) with instructions on the appeal and grievance process. 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/mmp/):

1) Required CMS denial language (utilizing only approved CMS denial letter templates);

2) Be typed in 12-point font;

3) 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;
   - The beginning sentence of every denial reason should be “Based on your IEHP DualChoice CalMediConnect Plan benefit or IEHP DualChoice Plan benefit” as applicable depending on the Member’s line of business on the date of the decision;
   - Non-covered benefit denials must cite the specific provision in the Evidence of Coverage (EOC) that excludes that coverage or the IEHP Member Handbook, CMS guideline or State/Federal regulations including the page number and/or State Regulations section.
   - Information on how the Member and practitioner can obtain the utilization criteria or benefits provision used in the decision;

4) Information for the Member regarding alternative treatment and direction for follow-up care; and

5) Information on how to file an oral or written expedited grievance, file a standard or fast appeal, or file an immediate review or appeal as applicable.
14. UTILIZATION MANAGEMENT

A. Utilization Management Delegation and Monitoring

The Delegate must have in place Quality Assurance (QA) procedures that monitor the items listed above. IEHP will monitor on a monthly basis through the Monthly Organization Determination Appeals and Grievances (ODAG) Standard Organization Determination (SOD) Universe and ODAG Expedited Organization Determination (EOD) Universe report. (See Attachment, “D-ODAG Universe 2016 SOD EOD Claims Data Dictionaries” in Section 21). The QA process will check for deficiencies in the medical rationale for the denial, the clarity of the language and the inclusion of correct information in the letter.

g. 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. This 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 modification. This written notification of denial or modifications must include language informing the practitioner of their right to appeal the decision to the Delegate’s Medical Director, Chief Medical Officer, or IEHP Medical Director.

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

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

i. IEHP or Delegate shall retain information on decisions, i.e., authorizations, denials, appeals, grievances, or modifications for a minimum period of ten (10) years.

j. For Delegates responsible for Medicare benefit only:

1) If a service request is covered by both Medicare and Medi-Cal, and does not meet Medicare criteria, but does meet Medi-Cal criteria, no denial letter is issued prior to forwarding to Health Plan (refer to Procedure E.2.a).

2) If a service request is not a covered benefit under Medicare, but is a covered benefit under Medi-Cal, no Medicare denial letter is needed prior to forwarding to Health Plan (refer to Section E.2.a).
14. UTILIZATION MANAGEMENT

A. Utilization Management Delegation and Monitoring

k. **Exceptions:** Prior authorization is not required for the following services:

1) Family Planning and Abortion Services;
2) Sexually transmitted disease (STD) treatment;
3) Sensitive and Confidential Services;
4) HIV testing and counseling at the Local Health Department;
5) Immunizations at the Local Health Department; and
6) 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 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 possess 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 14D, “Emergency Services.” All emergency care costs are covered when authorized by IEHP or its designee.

4. **Standing Referrals:** There must be 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. Authorization should be for a three to six (3-6) month period. For more information, please see Policy 14B.1, "Review Procedures - Primary Care Physician (PCP) Referrals".

5. **Behavioral Health:** Behavioral Health benefits for IEHP DualChoice Members are obtained through the IEHP Behavioral Health Program.

6. **Vision Services:** Vision is not a Medicare benefit unless specifically for covered lenses post cataract surgery. IEHP DualChoice Members may have additional limited benefits through Medi-Cal.

7. **Pharmacy Services:** Please refer to the Division of Financial Responsibility (DOFR) in your contract regarding pharmacy services.
14. UTILIZATION MANAGEMENT

A. Utilization Management Delegation and Monitoring

8. **Supplemental Benefits:** Supplemental benefits may vary and are the responsibility of the Health Plan. Please refer to IEHP’s website for a list of current benefits.

F. **Delegate UM Requirements** – The following requirements for UM processes must be met:

1. **Services Requiring Prior Authorization:** A list of services that require prior authorization or a list of services that do not require prior authorization must be maintained.

2. **Medical Necessity Determination:** Medical necessity determinations for a specific requested service is 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. 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

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

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. Denial letters must cite the specific non-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. **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/Group. Specialists caring for Members can request referrals directly.

G. **Documentation of Medical Information and Review Decisions:** Review decisions must be based 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 or Specialist must document the medical necessity for requested services, procedures, or referrals and submit all supporting documentation with the request.

2. **Reviewer Documentation:** 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, 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. **Documentation:** Procedures must be in place to log requests by date and receipt of information so that timeframes and compliance with those timeframes can be tracked. 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 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 and its Delegate do not provide compensation for practitioners or other individuals conducting utilization review for issuing denials of coverage or service. IEHP and its Delegates ensure 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. **Inpatient Stay:**
   a. Determine medical necessity
   b. Determine appropriate level of care
   c. Coordinate with hospital Case Manager discharge plan
14. UTILIZATION MANAGEMENT

A. Utilization Management Delegation and Monitoring

7. **Discharge Planning:** The UM process must include the following activities related to discharge planning:
   a. Determining level of care (SNF, office visit, home health, home without services);
   b. Arranging necessary follow-up care (home health, follow-up PCP or specialty visits, etc); and
   c. Facilitating transfer of the discharge summary and/or medical records, as necessary, to the PCP office.

8. **Out of Network Management:** Out of Network Management includes arranging for the transfer of Members, as medically appropriate, back into the IEHP network.

9. **Review of UM Data:** UM data related to Members is collected, reported, and analyzed for potential over or under utilization.
   a. UM data 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; or
      6) Emergency encounters.
   b. Presentation of above data in summary form to the UM Subcommittee for review and analysis at least quarterly upon receipt of necessary information;
   c. Presentation of selected data from above to 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 UM Subcommittee for trends by physicians for both over-utilization and under-utilization.

H. **Appeals and Grievance Non-Urgent Process:** IEHP maintains a formal Appeals and Grievance Resolution System to ensure a timely and responsive process for addressing and resolving all Member appeals and grievances. IEHP acknowledges and resolves UM related appeals and grievances in accordance with state and federal regulatory guidelines. The Member may file an appeal or grievance by phone, by mail, fax, website, or in person. IEHP resolves Member appeals and grievances within industry standard time frames. Please refer to Section 16 of this manual, “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 IPA’s network. Second opinions are authorized and arranged through the 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 function, decisions and notification of decisions to Member and 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, arrangements must be made for the Member to see a physician in the appropriate specialty. If the referral is denied, written notification must be sent to the Member including rationale for the denial. Members disagreeing with a denial of a second opinion may register an appeal through IEHP’s appeal and grievance process. Refer to Policy 14C, “Second Opinions” for more information.

J. **New Technology:** At least annually, 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. 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/IEHP 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 contracted 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 contracted 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-Delegate UM Responsibilities:** IEHP retains responsibility for selective UM activities for non-covered benefits, authorizations for vision services, pharmacy services
14. UTILIZATION MANAGEMENT

A. Utilization Management Delegation and Monitoring

and behavioral health authorizations. An electronic authorization system is maintained by IEHP to accommodate authorizations by IEHP for services that are not covered under the Medicare 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.

N. Monitoring Activities and Oversight of Delegate: IEHP monitors UM activities. The following oversight activities are performed to ensure compliance with IEHP UM and regulatory 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. 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 denial and approval universes and letters, Readmissions, annual & semi-annual work plan.

3. Review of ODAG Approval and Denial Universe Pre-Service Reports and Letters – All Delegates are required to submit monthly Organization Determination Appeals and Grievances (ODAG) Standard Organization Determination (SOD) Universe and ODAG Expedited Organization Determination (EOD) Universe report to IEHP listing the approved and denied referrals, clinical information, and denials and modifications of referrals from the previous month. Ten (10) Denial files including partial approvals (modifications) from the previous month are randomly selected from the monthly denial log. On a monthly basis, Ten (10) Approval files are randomly selected from the monthly ODAG report. Delegates are required to submit copies of all denial letters sent to Members and 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 and Director of Quality Management, and Quality Management Manager, or designee.

4. Focused Referral and Denial Audits – IEHP performs focused audits of the referral and denial process for Delegates. Please refer to policy 14 H, “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.

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

A. Utilization Management Delegation and Monitoring

procedures, actions, or behaviors that could potentially negatively impact Member health care.

6. Delegation Oversight Audits (DOA): IEHP performs monthly monitoring and auditing and the annual onsite Medical Management audits of all Delegates to review the UM process, that includes approved referral audit and non-emergent file review.

7. Joint Operating Meetings (JOMs): JOMs are intended to provide a forum to discuss issues and ideas concerning care for Members. JOMs are held with Hospitals and Delegates to address specific Provider Services, UM, QM, CM, grievance, study results, or any other pertinent quality issues. These meetings are designed to address issues from an operational level.

O. Confidentiality: IEHP recognizes that Members’ confidentiality and privacy are protected. It is the policy of IEHP and 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.

INLAND EMPIRE HEALTH PLAN

Chief Approval: Signature on file  Original Effective Date: January 1, 2007

Chief Title: Chief of Network Officer  Revision Date: January 1, 2017
14. UTILIZATION MANAGEMENT

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

**APPLIES TO:**

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

**POLICY:**

A. IEHP delegates the responsibility for providing general medical care for Members to Primary Care Physicians (PCPs).

B. PCPs are responsible for requesting specialty care, diagnostic tests, and other medically necessary services through their 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 for approval, in accordance with Policy 14B1a, “Review Procedures – Primary Care Physician (PCP) Referral - 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.”
14. UTILIZATION MANAGEMENT

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

C. For expedited referrals, Member should receive notice of decision within seventy-two (72) hours of receipt of request. For routine referrals, Member should receive notice of decision within fourteen (14) calendar days.

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

E. Referrals to specialists or out-of-network practitioners require documentation of medical necessity, rationale for the requested referral and prior authorization. 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 may have to obtain prior authorization.
   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 by IEHP.

G. Denial logs and letters for in-network and out-of-network denials and 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 Members are initiated by the PCP through IEHP as outlined in Policies 12.D.1, “Behavioral Health - Behavioral Health Services” and 12.D.2, “Behavioral Health - Alcohol and Drug Treatment Services.”

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IEHP Provider Policy and Procedure Manual 01/17 Medicare DualChoice
14. UTILIZATION REVIEW

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

APPLIES TO:

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

POLICY:

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

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 (Emergent, Urgent, or Routine);
   6. Reason for referral or diagnosis;
   7. Service/Activity Requested;
   8. Date referral returned;
   9. Requesting Provider;
   10. Requested Provider;
   11. Requesting 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, to obtain assistance from IEHP 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

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

INLAND EMPIRE HEALTH PLAN

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14. UTILIZATION MANAGEMENT

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

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

POLICY:
A. 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 (877) 273-4347 or for TTY (800) 718-4347.
D. PCPs are responsible for coordinating the care of the Member in consultation with the specialist, 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 the Medical Director or designee, within three (3) business days if a Member needs continuing care from a specialist.
B. Review Procedures
   2. Standing Referral/Extended Access to Specialty Care

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 in writing, using the designated form (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.

G. After approval of the standing referral or extended access to specialty care with or without a treatment plan, the PCP, specialist will be notified within twenty-four (24) hours of the decision. Member must be notified in writing of the specifics of the determination within two (2) business days of the determination.

H. 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, uncontrollable seizures among others; and
   8. GI conditions such as severe peptic ulcer and chronic pancreatitis among others.

I. Potential conditions necessitating extended access to a specialist or specialty care center and/or treatment plan include but are not limited to the following:
   1. Hepatitis C;
2. Lupus;
3. HIV;
4. AIDS;
5. Cancer;
6. Potential transplant candidates;
7. Severe and progressive neurological conditions;
8. Renal failure; and
9. Cystic fibrosis.

J. 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 (CME), (as directed by the Medical Board of California), in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-positive 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 HIV-positive; and
14. UTILIZATION MANAGEMENT

B. Review Procedures

2. Standing Referral/Extended Access to Specialty Care

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

K. 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; and
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.

L. The Member may be referred to a non-network provider if 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 Medical Director and/or PCP in consultation with IEHP’s Chief Medical Officer, when warranted.

M. Any medical condition requiring frequent or repeat visits to a specialist should be considered by the PCP for submission of a standing referral or extended access to a specialty care referral.

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
14. UTILIZATION MANAGEMENT

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

Referral/Extended Access 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.

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

O. 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.”

P. 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. Members can be referred to out-of-network practitioners when appropriate specialty care is not available within the network.

   B. All services for out-of-network providers must be coordinated adequately and timely.

   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. Members can be referred to an out-of-network HIV/AIDS specialist when 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 Medical Director and/or PCP in conjunction with the IEHP’s Medical Director, as warranted.

INLAND EMPIRE HEALTH PLAN

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IEHP Provider Policy and Procedure Manual
Medicare DualChoice

01/17 MA_14B2 Page 5 of 5
14. UTILIZATION MANAGEMENT

C. Second Opinions

APPLIES TO:

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

POLICY:

A. Primary Care Physicians (PCPs), Specialists, and Members (if the 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 (877) 273-4347. IEHP’s Member Services staff directs the Member to an IEHP Care Manager. The Care Manager assists the Member in contacting his/her 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 modified, the Delegate provides written notification to the Member, including the rationale for the denial or modification, alternative care
C. Second Opinions

recommendations, and information on how to appeal this decision. Request may be denied if the 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. Reasons for providing or authorizing a second opinion include, but are not limited to, the following:

1. The Member questions the reasonableness or necessity of recommended surgical procedures;

2. The Member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment including but not limited to a serious chronic condition;

3. Clinical indications are not clear or are complex and confusing, a diagnosis is questionable due to conflicting test results, or the treating PCP/specialist is unable to diagnose the condition and the Member requests an additional diagnostic opinion;

4. The treatment plan in progress is not improving the medical condition of the Member within an appropriate time period given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance
14. UTILIZATION MANAGEMENT

C. Second Opinions

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.

K. 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.

L. 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 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.

M. The Delegate is responsible for submitting a copy of all authorizations, modifications, and denials of second opinions to the PCP.

N. 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.

O. 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.

P. 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 (See Attachment, “BH Initial Evaluation Coordination of Care Report” in Section 12).

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.

Q. 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).

R. Mandated timeframes for decision including approval, denial or 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.”

S. If the referral is denied or modified, the Delegate provides written notification to the Member including rationale for the denial or modification, alternative care recommendations, and information on how to appeal this decision. The Member,
C. Second Opinions

Member’s Representative, or practitioner appealing on behalf of the Member, disagreeing with a denial of a second opinion, may appeal through the IEHP Grievance process.

T. IEHP’s Senior 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

D. Emergency Services

APPLIES TO:

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

POLICY:

A. Providers must render services to Members who present themselves to an Emergency Department (ED) for treatment of an emergent or urgent condition. Per federal law, at a minimum, services must include a Medical Screening Exam (MSE).

B. Delegates are responsible for payment of professional services rendered to Members at the ED, per their contract with IEHP and this policy. Delegates with a full risk contract are responsible for the facility component. For all other Delegates, 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.
D. Emergency Services

E. If it is determined that the Member’s condition was not emergent, IEHP or Delegates is responsible for the MSE, at a minimum based on individual contracts. The Member does not need to be notified 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.

F. Emergency services can be subject to retrospective review. IEHP 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 Primary Care Physician (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.

G. Delegates are encouraged to develop contractual arrangements with EDs and Physician Groups.

H. 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.

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

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. 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
D. Emergency Services

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.

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. IEHP or 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. In the event that the ED is unable to reach the responsible PCP or designee, the call time and phone number must be documented in the ED record and the ED must provide medically necessary care.

E. 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.
14. UTILIZATION MANAGEMENT

D. Emergency Services

F. Examples of non-emergent ED visits could include:
   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.
14. UTILIZATION MANAGEMENT

E. Pre-Service Referral Authorization Process

APPLIES TO:

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

POLICY:

A. 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’s or IEHP’s referral authorization process.

B. The PCP must review any referral from an affiliated mid-level practitioner, i.e. Nurse Practitioner (NP) or Physician Assistant (PA), prior to the submission of the referral. If there are questions about the need for treatment or referral, the PCP must see the Member.

C. IEHP and its 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 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;
E. Pre-Service Referral Authorization Process

1. The diagnosis (ICD codes) and procedure (CPT) codes;
2. Pertinent clinical information supporting the request; and
3. 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 visits) for medically necessary specialty care (See Attachment, “Specialty Office Service Authorization 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).

F. IEHP will accept only the listed request types for continued services from contracted
14. UTILIZATION MANAGEMENT

E. Pre-Service Referral Authorization Process

DME vendors. Approval will be based on medical guidelines and frequency limitations.

1. Home Oxygen and oxygen supplies must have saturation level 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

G. 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.

H. 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 – IEHP DualChoice” 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.

I. IEHP and its Delegates should monitor the PCP’s rates 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.

J. 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.

K. 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.

L. Specialists are required to forward consultation notes to the PCP within two (2) weeks of the visit.
14. UTILIZATION MANAGEMENT

E. Pre-Service Referral Authorization Process

M. For IEHP DualChoice Members that have their Medi-Cal with IEHP, all request for services covered under the Medi-Cal benefit should be faxed to IEHP immediately upon receipt to (909) 890-5751. Members should be notified that 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
14. UTILIZATION MANAGEMENT

F. Wheelchair Purchase Referral Procedure

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

POLICY:
A. Delegates with a Global or Shared Risk are responsible for authorizing custom wheelchair purchases on their own behalf.
B. Delegates are responsible for authorizing non-custom wheelchair purchases and wheelchair rentals according to their individual contracts.
C. Medical necessity evaluations are required for custom wheelchair purchase requests that are processed through IEHP or the Delegate. These evaluations will be performed by a physiatrist, orthopedist, neurologist, rheumatologist, or other qualified medical professional as authorized by IEHP.
D. Custom wheelchair requests should be reviewed by IEHP or Delegate’s Medical Director to ensure criteria is met.
E. IEHP or Delegate should coordinate a Seating Evaluation, either facility-based or in-home, for Members who need custom wheelchairs, power wheelchairs, non-routine wheelchair therapeutic seat cushions, and/or wheelchair positioning systems.
F. IEHP or Delegate is responsible for repairs and maintenance of custom wheelchairs for qualified individuals as per Delegate’s contract.

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. Custom wheelchair purchase requests that are processed through a Delegate shall follow the Delegate's prior authorization procedures.
C. IEHP or Delegate’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 – IEHP DualChoice” in Section 14).
F. Wheelchair Purchase Referral Procedure

D. IEHP will issue denial letters for services denied by IEHP, and the Delegate will issue denials for the services denied by them.

E. IEHP or Delegate’s UM Department will send notification to the requesting Provider, PCP, and seating clinic regarding the determination.

F. If approved, IEHP or Delegate will arrange for the Member to be assessed for a Seating Evaluation, either facility-based or in-home, to determine equipment needs.

G. Unless otherwise informed, the equipment will be delivered to the Member’s home.

H. The Seating Evaluator will contact the Member and schedule a post delivery assessment that will include the DME vendor, as needed.
14. UTILIZATION MANAGEMENT

G. Expedited Initial Organization Determinations (EIOD)

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

POLICY:
A. IEHP and Delegates process Expedited Initial Organization Determinations (EIOD) for time sensitive situations for Members when the standard timeframe for issuing a determination could seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function.
B. The Member, applicable representatives, or treating practitioner may submit an oral or written request for an EIOD.

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, applicable representatives, or treating practitioner may submit requests for EIODs verbally, by fax, or in writing.
B. A Member, applicable representatives, or a practitioner may request an EIOD when:
   1. The Member or practitioner believes that waiting for a decision under the standard timeframe could place the Member’s life, health, or ability to regain maximum function in serious jeopardy; and
   2. The Member believes the Health Plan should furnish directly or arrange for services to be provided (when the Member has not already received the services outside of the Health Plan).
C. EIODs may not be requested for cases in which the only issue involves claims payment for services the Member has already received.
D. The seventy-two (72)-hour timeframe for a determination regarding the requested service(s) commences when IEHP or Delegate receives the request for an EIOD.
E. An EIOD is automatically provided when the request is made or supported by a practitioner. The practitioner must indicate, either orally, or in writing, that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function.
G. Expedited Initial Organization Determinations (EIOD)

F. For a request made by a Member or applicable representatives, IEHP and Delegates must expedite the review of a determination if IEHP or the Delegate finds that applying the standard timeframe may jeopardize the Member’s health, life, or ability to regain maximum function.

G. If clinical information is needed from a non-contracted practitioner, IEHP or the Delegate will request this information within twenty-four (24) hours of the initial request for an EIOD. Non-contracted practitioners must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist in meeting the required time frame. Regardless of whether or not IEHP or the Delegate must request clinical information from non-contracted practitioners, IEHP and Delegates are still responsible for meeting the same timeframe and notification requirements for EIODs.

H. If it is determined that the Member’s condition does not warrant an expedited determination, the Member will be verbally notified within seventy-two (72) hours of receipt of the request (includes weekends and holidays) followed by written notification within three (3) calendar days of the verbal notification. The request will automatically be processed within the standard timeframe of fourteen (14) calendar days for a determination beginning the day the request was received for an EIOD. The Expedited Criteria Not Met notice must:

1. Explain that the request will be processed using the fourteen (14)-calendar day timeframe for standard determinations;

2. Inform the Member of the right to file an expedited grievance if he or she disagrees with the decision to not expedite the determination, give instructions for filing an expedited grievance; give the expedited grievance process timeframe, and an explanation of the criteria for expedited reviews;

3. Inform the Member of the right to resubmit a request for an EIOD if the Member gets any practitioner’s support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function. The request will be expedited automatically; and

4. Provide instructions about the expedited grievance process and its timeframes.

I. If the request is approved for an EIOD, the determination must be made in accordance with the following requirements:

1. Whether the decision is to approve, modify, or deny, the Member and practitioner must be notified of the decision within seventy-two (72) hours of receipt of the request.

2. If the initial notification to the Member of the expedited determination is verbally, then written notification to the Member must occur within three (3) calendar days of the verbal notification. All verbal communication with Members must be
G. Expedited Initial Organization Determinations (EIOD)

documented with time, date, and name of contact person with initials of IEHP or Delegate's staff making the call, with each attempt.

3. If only written notification is given for a modification or denial determination, the Member and practitioner must receive the notification within seventy-two (72) hours of receipt of the EIOD request.

J. Written communication regarding a modification or denial must be written in a manner that is understandable and sufficient in detail so that the Member and practitioner can understand the rationale for the decision. The Notice of Denial of Medical Coverage (NDMC) letter must include:

1. The specific reason for the denial that takes into account the Member’s presenting medical condition, disabilities, and if any, special language requirements;
2. The determination is based upon Medicare Coverage Guidelines;
3. Information regarding the Member’s right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the Member’s behalf;
4. A description of both the standard and expedited reconsideration processes that include conditions for obtaining an expedited reconsideration, and the other elements of the appeals process; and
5. The Member’s right to submit additional evidence in writing or in person.

K. An extension of no more than fourteen (14) calendar days may be allowed to perform the review under the following circumstances:

1. There is justification for additional information, (e.g., allowing for additional diagnostic procedures or specialty consultations) and there is documentation on how this delay is in the interest of the Member.
2. The Member or practitioner requests an extension of time to provide IEHP with additional information.
3. The practitioner requesting the EIOD is not contracted and the clinical information necessary to make the determination is not submitted within seventy-two (72) hours. An attempt to contact the non-contracted provider will be made within twenty-four (24) hours of receipt.

L. Extensions must not be used to pend organization determinations while waiting for medical records from contracted Providers.

M. The Member will be notified in writing of the reason for the delay, utilizing the Extension Needed for Additional Information – Expedited and Standard Initial Determination letter, and informed of the right to file an expedited grievance (oral or written) if he or she disagrees with the decision for an extension. The written notification for the extension will include the clinical information needed, or the test or examination required.
14. UTILIZATION MANAGEMENT

G. Expedited Initial Organization Determinations (EIOD)

N. Timeframe and notification requirements for all EIOD requests will be identified and reviewed on the Denial and Approval universe submitted by IPAs on a monthly basis (See Attachments, “C-ODAG Universe 2016 EOD ICE Template” in Section 21).
14. UTILIZATION MANAGEMENT

H. Referral and Denial Audits

APPLIES TO:
A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) 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 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 ; and
   b. Critical Element #1: Member Notification; and
   c. Critical Element #2: Member Language; and
   d. Critical Element #3: Appropriate use of Criteria; and
   e. Critical Element #4: Correct Template.
H. Referral and Denial Audits

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% or greater for two (2) consecutive months, on any of the above audit areas, 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 actions 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 randomly selected from the submitted monthly ODAG universes in that month 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;
   2. The Delegate may be frozen to new Member enrollment until the Delegate passes the monthly audit for two (2) consecutive months;
14. UTILIZATION MANAGEMENT

H. Referral and Denial Audits

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

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 – IEHP DualChoice” 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 audit 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 an aggregate of the monthly File Reviews for the period of July 1st of the previous calendar year thru June 30th of the current year.

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:

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.
14. UTILIZATION MANAGEMENT

H. Referral and Denial Audits

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% and 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 Delegation Oversight Audit (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 to 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:
14. UTILIZATION MANAGEMENT

H. Referral and Denial Audits

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

I. Utilization Management Reporting Requirements

APPLIES TO:

A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) 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. 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. Skilled Nursing Facility (SNF) Admissions:

1. All Delegates must notify IEHP of all SNF admissions from the previous month by the 15th of the current month and/or as soon as it is determined the Member will transmit to custodial care.

   a. Long Term Care (LTC) Data Sheet – Delegate must include all data listed on the “LTC Data Sheet” (See Attachment, “LTC Data Sheet” in section 14). Submit LTC Data Sheet along with factsheet electronically using a IEHP SFTP server.

B. Monthly and Quarterly Reporting Requirements:

1. Reporting requirements include a monthly and quarterly 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 approved or denied and include the following:

   a. Monthly Approval File Review – No later than the 15th day of the month following the reporting month, IEHP Delegation Oversight will review ten (10) Approval Files with the supporting documentation including Approval Letters used to make the decisions from the Organization Determinations Appeals and Grievance (ODAG) Approvals Universe Pre-
14. UTILIZATION MANAGEMENT

I. Utilization Management Reporting Requirements

Service for CMC. Delegate must submit all required documentation related to the file selections by the 15th day of the following month.

b. Monthly Denials and Partial Approvals (Modifications) – Must be submitted in excel file format via the ODAG – Denial Universe – Payment and Pre-Services Template and include all referral and clinical information, and copies of all denial letters.

c. EIOD Log – Data elements from this log will now be reported on the ODAG Universe Pre-Service report, no requirement for a separate report.

C. Semi-Annual Reporting Requirements:

1. UM Semi-Annual Reports must be submitted to IEHP on a semi-annual basis including February 15th and August 15th. The reports should include, at a minimum, UM goals and activities, trending of utilization activities for under and over utilization, Member and practitioner satisfaction, interrater reliability, and improvement and a narrative of barriers and improvement activities. The Semi-Annual report due in February must also include the:

a. UM Program Annual Evaluation/ICE Report that is the IPAs evaluation of the overall effectiveness of the UM Program, including whether or not goals were met, data, performance rates, barrier analysis, and improvement activities; and

b. UM Workplan Update. Submit an update of the Annual Workplan which includes planned activities for the year, 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. 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 completed annually 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/Initial ICE Report: 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.

E. All reports identified on the Medicare Provider Reporting Requirements Schedule must
I. Utilization Management Reporting Requirements

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

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

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

INLAND EMPIRE HEALTH PLAN

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<th>Signature on file</th>
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14. UTILIZATION MANAGEMENT

J. Long Term Care (LTC) – Custodial Level

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

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

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

PROCEDURES:
A. IEHP will become financially responsible for facility fees once it has been determined that the Member requires a custodial level of care or when the allotted one hundred (100) skilled days have been exhausted. The IPA remains responsible for professional fees for the month of initial enrollment into the plan/IPA and admission to custodial care and month following.
B. Please refer to the Medi-Cal Provider Manual for information on custodial care under
14. UTILIZATION MANAGEMENT

J. Long Term Care (LTC) – Custodial Level

Medi-Cal.
14. UTILIZATION MANAGEMENT

K. Long Term Care (LTC) - Skilled Level

APPLIES TO:

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

C. IEHP DualChoice Members do not need a three (3) days acute hospital stay prior to admission to an LTC.

PURPOSE:

A. To promote the appropriate placement of Members into long term care when daily skilled nursing or rehabilitation services cannot be provided in environments of lower levels of care, or as an appropriate plan for discharge from the hospital.

B. To ensure all nursing facilities and subacute facilities comply with all regulatory guidelines, including care coordination which will be facilitated by IEHP.

PROCEDURES:

A. Appropriate LTC skilled level placement involves the following factors:

1. The Member requires skilled nursing services or skilled rehabilitation services on a daily basis.

2. Only contracted LTC facilities are utilized unless none are available, then a letter of agreement (LOA) is requested.

3. The Member’s eligibility and schedule of benefits are verified prior to authorizing appropriate services. Within the first five (5) days of each month, eligibility is re-evaluated for Members remaining in 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 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 placement from home.
K. Long Term Care (LTC) - Skilled Level

D. Prior to issuing verbal authorization for an admission, all the clinical reviews, the 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 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 until discharge. Concurrent review can be performed by either on-site chart review or telephonically.

G. Reviews should include physician communication and ongoing communication with other healthcare professionals involved in the Member’s care as necessary. Authorization decisions must be made within 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;
7. Expected outcome of the Member’s health status with 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, “LTC Initial Review Form” and “LTC Follow-up Review Form” 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 14J, “Long Term Care (LTC) – Custodial Level” in Section 14 for more information;
   c. Intermediate care (based upon the Member’s benefit);
   d. Adult day care (based upon the Member’s benefit; see Policy 12I,
14. UTILIZATION MANAGEMENT

K. Long Term Care (LTC) - Skilled Level

“Community Based Adult Services (CBAS)” – formerly known as Adult Day Health Care (ADHC)”; or child day care.

e. Family education and training;

f. Community networks and resources.

I. Appropriately licensed staff must assist in the evaluation and placement of Members into LTC facilities including involvement in the development, management, and monitoring of Member treatment plans.

J. The treatment plan is implemented, evaluated, and revised by the team of Providers and staff including, but not limited to, UM and/or CM staff, physicians, long term care Providers and staff, and IEHP or the IPA, as appropriate. The Member and family also are involved in the treatment plan implementation process to the extent necessary.

K. The UM/CM staff, together with the interdisciplinary team of Providers and staff, guide the Member toward meeting the treatment plan goals that include transfer to a lower level of care when it is medically appropriate.

L. UM/CM staff assists in the discharge planning process and the transfer and follow-up of the Member to the next level of care.

M. Transfer to a board and care or home environment is initiated when it is determined that the Member is at a “custodial” level of care and can be safely managed at a lower level of care (based upon the Member’s benefit).

N. Authorization will be given for bed hold with a physicians order only.

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.

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.

O. Financial responsibility for IEHP DualChoice Members continues for up to one hundred (100) days per benefit period. IEHP or IPA will ensure that the Member is admitted to a contracted facility, as applicable. IEHP or IPA is responsible for notifying the IEHP DualChoice Member, assigned PCP, and LTC facility that the benefits expire after one hundred (100) days of inpatient care per benefit period, and again prior to the Member exceeding the one hundred (100) days benefit limit.

P. 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 via phone or fax.
14. UTILIZATION MANAGEMENT

K. Long Term Care (LTC) - Skilled Level

Q. Practitioners and Members are given a written or electronic notification of the decision of non-coverage of further LTC skilled no later than two (2) calendar days prior to proposed termination of services.

R. The Notice of Medicare Non-Coverage (NOMNC) letter may be delivered earlier if the date that coverage will end is known.

S. If the expected length of stay or service is two (2) days or less, the NOMNC letter must be given on admission.

T. The NOMNC should not be used when it is determined that the Member’s services should end based on the exhaustion of benefits, (such as the one hundred (100)-day long term care limit per benefit period). If the Provider is unable to personally deliver the NOMNC to a person legally acting on behalf of a Member, then the Provider should telephone the representative to advise him or her of the following:

1. The proposed termination of services; and
2. The Member’s appeal rights must be explained and the name and telephone number of the Quality Improvement Organization (QIO) should be provided.
3. The date of the conversation with the Member’s representative is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date.
4. When direct phone contact cannot be made, the notice is sent to the Member’s representative by certified mail, return receipt requested. The date that someone at the representative’s address signs (or refuses to sign) the receipt is the date of receipt for the NOMNC letter.
5. The Delegate must issue the Detailed Explanation of Non-Coverage (DENC) to QIO no later than the date specified, and the facility must issue a copy to the Member.

U. On the 15th of each month, IPAs must notify IEHP of Members who are receiving skilled care as of the previous month or are estimated to require long term care greater than the one hundred (100) days LTC skilled limit per benefit period, by faxing the Long Term Care (LTC) Data Sheet along with the face sheet to (909) 477-8553. Please see Policy 14I, “Utilization Management Reporting Requirements” for more information.

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<tr>
<td>Chief Title: Chief of Medical Services</td>
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IEHP Provider Policy and Procedure Manual 01/17 Medicare DualChoice MA_14K Page 4 of 4
14.  UTILIZATION MANAGEMENT

L.  Hospice Services

**APPLIES TO:**
A.  This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

**POLICY:**
A.  IEHP or those IPAs delegated to perform Utilization Management are responsible for the initial hospice evaluation with a Medicare certified hospice Provider.
B.  All subsequent hospice services should be billed under fee-for-service Medicare.
C.  IEHP DualChoice Members must use Medicare certified hospice Providers.

**PROCEDURE:**
A.  Requests for initial hospice evaluation by a Medicare certified hospice Provider require prior authorization. Please refer to Policy 14E, “Pre-Service Referral Authorization Process” for more information.
14. UTILIZATION MANAGEMENT

M. Acute Admission and Concurrent Review

APPLIES TO:

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

POLICY:

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

B. Prior to any termination or non-coverage of services the Provider of the service must provide valid delivery of the written notification to the Member and/or the Member’s Representative of the decision to terminate services.

C. Valid delivery means that the Member and/or Member’s Representative must be able to understand the purpose and contents of the notice in order to sign for receipt of it.

D. If the Member is not able to comprehend the contents of the notice, the notice must be delivered to and signed by an authorized representative for the Member.

E. If the Member refuses to sign the notice, the notice is still valid as long as the Provider documents that the notice was given, but the Member refused to sign.

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 (Case Management or Admitting Department, including those planned and unplanned transitions. 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
14. UTILIZATION MANAGEMENT

M. Acute Admission and Concurrent Review

acute care (LTAC), skilled nursing facility (SNF), or acute rehabilitation.

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

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, and 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.

K. 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.

L. Facilities, including acute, rehabilitation, long term acute care and psychiatric, must notify Members who are inpatient about their hospital discharge appeal rights. Facilities must issue the Important Message from Medicare (IM) within two (2) calendar days of admission, must obtain the signature of the beneficiary or his or her representative and provide a copy at that time to the Member/Member’s Representative.

1. A follow up copy must be delivered no more than two (2) calendar days before the planned date of discharge.

2. When discharge cannot be predicted in advance, the follow up copy may be delivered as late as the day of discharge giving the beneficiary at least four (4)
14. UTILIZATION MANAGEMENT

M. Acute Admission and Concurrent Review

hours to consider their right to request a Quality Improvement Organization (QIO) review.

3. If delivery of the original IM is within two (2) calendar days of the date of discharge, no follow up notice is required.

4. The Detailed Notice of Discharge must be completed with all necessary information and delivered to the Member by the facility.

M. 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;
3. Communicate the medical assessment to UM/CM staff either verbally or in writing;
4. Continue to document medical necessity in the medical record for the duration of the Member’s hospital stay.

N. 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).

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

M. Acute Admission and Concurrent Review

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### 14. UTILIZATION MANAGEMENT

#### Attachments

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<tr>
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<tr>
<td>Approved Referral Audit Tool</td>
<td>14I</td>
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<tr>
<td>Health Plan Referral Form for Out-of-Network and Special Services</td>
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<tr>
<td>IPA Denial Log Review Tool – IEHP DualChoice</td>
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<tr>
<td>Long Term Care (LTC) Data Sheet</td>
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<td>Long Term Care (LTC) Follow-up Review Form</td>
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<tr>
<td>Standing Referral Extended Access to Specialty Care</td>
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<td>UM Timeliness Standards – IEHP Dual Choice</td>
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**IPA Approval Review Tool**

**Data Dictionary**

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**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.

**Sample Data:**

| (a) Approval Tracking # | (b) File Type Requested | (c) Auto Authorization | (d) Referral Request Date | (e) Referral Received Date | (f) Decision Date | (g) Written Physician Notification Date | (h) Decision Time | (i) Member Written Notification | (j) Physician Written Notification | (k) Member Language | (l) Practitioner Language | (m) Clinical Information | (n) Referral Form | (o) Correct Template | (p) Points Received | (q) Points Possible | (r) Individual Score |
|------------------------|------------------------|------------------------|---------------------------|---------------------------|----------------|-------------------------------|----------------|-----------------------------|-----------------------------|----------------|----------------|------------------|----------------|----------------|----------------|----------------|----------------|----------------|
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| 4                      | 3                      | 3                      | 3                         | 3                         | 3              | 3                             | 3              | 3                           | 3                          | 3              | 3              | 3                | 3              | 3              | 3              | 3              | 3              | 3              |
| 5                      | 4                      | 4                      | 4                         | 4                         | 4              | 4                             | 4              | 4                           | 4                          | 4              | 4              | 4                | 4              | 4              | 4              | 4              | 4              | 4              |
| 6                      | 5                      | 5                      | 5                         | 5                         | 5              | 5                             | 5              | 5                           | 5                          | 5              | 5              | 5                | 5              | 5              | 5              | 5              | 5              | 5              |
| 7                      | 6                      | 6                      | 6                         | 6                         | 6              | 6                             | 6              | 6                           | 6                          | 6              | 6              | 6                | 6              | 6              | 6              | 6              | 6              | 6              |
| 8                      | 7                      | 7                      | 7                         | 7                         | 7              | 7                             | 7              | 7                           | 7                          | 7              | 7              | 7                | 7              | 7              | 7              | 7              | 7              | 7              |
| 9                      | 8                      | 8                      | 8                         | 8                         | 8              | 8                             | 8              | 8                           | 8                          | 8              | 8              | 8                | 8              | 8              | 8              | 8              | 8              | 8              |
| 10                     | 9                      | 9                      | 9                         | 9                         | 9              | 9                             | 9              | 9                           | 9                          | 9              | 9              | 9                | 9              | 9              | 9              | 9              | 9              | 9              |
| Selected Individual Scores: | | | | | | | | | | | | | | | | | | | | | |
| 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| Total Score: | 0 | 80 | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% |

**IPA:**

- Service Month:
- Review Date:
- Reviewer:
This form is for services requiring health plan review

1. Referrals

Date: ___________________________  (To be completed by IEHP)

- Urgent/Expeditied - Decision w/in 72 hours
- Routine
- Patient Requested
- Retro
- CPO Services
- CBAS

Auth/Tracking Number: _______________________

Auth/Expiration Date: _______________________

2. General Information

Member Name (please print)  DOB  ID #

Plan (select one)  Medi-Cal  Healthy Families  Healthy Kids  Non-State Programs  Open Access  Medicare

Address  City  Zip  Phone

Diagnosis (Required)  ICD-10 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.

Refered to (must refer to a specialist within network)  Specialty:  NPI#:  Phone

Address:  City:  Zip  Fax

Referring Provider (please print)  Phone  Fax

Address  City  Zip

Referring Provider Signature (REQUIRED)  NPI#:  Date

3. Service Requested

Service Requested (check one)  Consult  Follow-up  DME  Home Health  Other

Service Location/Facility:  Office  Outpatient  Inpatient

Procedure Requested (Submit supportive documentation with the claim to justify the Evaluation and Management (E & M) code if this service will occur the same day as the procedure.)  CPT Code (Required)

Facility Address  Phone  Fax

4. Completed by IEHP

Date Additional Information Required:  Date Additional Information Received:  Approved  Modified  Other

Assigned IPA:  

Medical Reviewer Comments

Medical Reviewer Signature (Circle Title: MD, DO, RN, LVN, Coordinator)  Date  Criteria utilized in making this decision is available upon request by calling IEHP (866) 725-4347.

Upon acceptance of referral and treatment of the member, the physician/provider agrees to accept IEHP contracted rates. This referral/authorization verifies medical necessity only. Payments for services are dependent upon the Member’s eligibility at the time services are rendered.

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) 890-46335751
## IPA Denial Log Review Tool

**IPA:**

- **Service Month:**
- **Review Date:**
- **Reviewer:**

### Comments

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### Data Dictionary

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<tr>
<th>Data Dictionary</th>
<th>Policy and/or Regulation</th>
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<tr>
<td>a Denial Tracking Number</td>
<td>The member located on the referral form for tracking purposes. Provided from the Delegate file submission.</td>
</tr>
<tr>
<td>b File Type Requested</td>
<td>Pre-Service Routine, Pre-Service Expedited, Post Service Retroactive Review. CMS UM Timeliness, IEHP Provider Policy and Procedure Medicare DualChoice 07/14 MA_14A.8 - 10</td>
</tr>
<tr>
<td>c Referral Request Date</td>
<td>Date the referral was sent to Delegate for review. CMS UH Provider Policy and Procedure Manual Medicare DualChoice 07/14 MA_14A.11</td>
</tr>
<tr>
<td>d Referral Received Date</td>
<td>Date the referral was received by the Delegate for a decision. CMS UH Provider Policy and Procedure Manual Medicare DualChoice 07/14 MA_14A.11</td>
</tr>
<tr>
<td>e Decision Date</td>
<td>Date the Delegate decision was made by the Delegate to Approve, Modify or Deny the case. CMS UH Provider Policy and Procedure Manual Medicare DualChoice 07/14 MA_14A.9 - 11</td>
</tr>
<tr>
<td>f Written Physician Notification Date</td>
<td>Date of the physician written notification. CMS UM Timeliness, IEHP Provider Policy and Procedure Manual Medicare DualChoice 07/14 MA_14A.9 - 11</td>
</tr>
<tr>
<td>g Physician Availability to Discuss</td>
<td>Physician will be available to discuss determinations based on medical appropriateness. CMS UH Provider Policy and Procedure Manual Medicare DualChoice 07/14 MA_14A.12</td>
</tr>
<tr>
<td>h Decision Timeliness</td>
<td>Delegate decision to approve, modify, deny a referral request in a timely manner according to regulations. CMS UH Timeliness, IEHP Provider Policy and Procedure Manual Medicare DualChoice 07/14 MA_14A.8 - 10</td>
</tr>
<tr>
<td>i Member Notification</td>
<td>Standards: Evidence the Member was contacted regarding their denial by day 12 of request (must be within the 14 calendar day timeframe). Expedited: Evidence the Member was contacted regarding their denial within 72 hours. If Member was contacted by phone, an additional 3 days may be added to the timeframe from the date of the call. CMS UH Provider Policy and Procedure Manual Medicare DualChoice 07/14 MA_14A.8 - 10</td>
</tr>
<tr>
<td>j Physician Reviewed</td>
<td>Physician reviewed all denial for medical necessity. CMS UH Provider Policy and Procedure Manual Medicare DualChoice 07/14 MA_14A.6</td>
</tr>
<tr>
<td>k Clinical Information</td>
<td>Clinical information supporting the request. CMS UH Provider Policy and Procedure Manual Medicare DualChoice 07/14 MA_14A.12</td>
</tr>
<tr>
<td>l Alternative Direction</td>
<td>The Member is given alternative direction for follow-up care. CMS UH Provider Policy and Procedure Manual Medicare DualChoice 07/14 MA_14A.12</td>
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### Selected Individual Scores:

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### Total Score:

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Total Score: 0 360
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<table>
<thead>
<tr>
<th>n</th>
<th>Physician Written Notification</th>
<th>Written Notification to the physician of the requested referral decision by the Delegate.</th>
<th>CMS, IEHP Provider Policy and Procedure Manual Medicare DualChoice 07/14 MA_14A.B - 10</th>
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<tbody>
<tr>
<td>o</td>
<td>Member Language</td>
<td>The denial letter Reason is clear &amp; concise.</td>
<td>CMS, IEHP Provider Policy and Procedure Manual Medicare DualChoice 07/14 MA_14A.11</td>
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<tr>
<td>p</td>
<td>Practitioner Language</td>
<td>The denial letter reason is clear &amp; concise.</td>
<td>CMS, IEHP Provider Policy and Procedure Manual Medicare DualChoice 07/14 MA_14A.12</td>
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<tr>
<td>q</td>
<td>Appropriate use of Criteria</td>
<td>The correct criteria hierarchy utilized for denied services.</td>
<td>CMS, IEHP Provider Policy and Procedure Manual Medicare DualChoice 07/14 MA_14A.2</td>
</tr>
<tr>
<td>r</td>
<td>Correct Template</td>
<td>Use of IEHP issued CMS Template</td>
<td>CMS, IEHP Provider Policy and Procedure Manual Medicare DualChoice 07/14 MA_14A.12 &amp; Policy 16</td>
</tr>
</tbody>
</table>

| s | Points Received | Total points earned from letters (g)-(r) above. | N/A |
| t | Points Possible | Total points possible from letters (g)-(r) above, excluding non applicable elements. | N/A |
| u | 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 |
| v | Decision Timeliness CAP | Files that earn a "0" score for Decision Timeliness will produce an "X" in this cell. An "X" in this cell will result in a CAP for Decision Timeliness. | N/A |
| w | Member Language CAP | Files that earn a "0" score for Member Language will produce an "X" in this cell. An "X" in this cell will result in a CAP for Member Language. | N/A |
| x | Appropriate use of Criteria CAP | Files that earn a "0" score for Appropriate use of Criteria will produce an "X" in this cell. An "X" in this cell will result in a CAP for Appropriate use of Criteria. | N/A |
| y | Correct Template CAP | Files that earn a "0" score for Correct Template will produce an "X" in this cell. An "X" in this cell will result in a CAP for Correct Template. | N/A |
# INLAND EMPIRE HEALTH PLAN
## LONG TERM CARE (LTC) DATA SHEET

<table>
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<tr>
<th>IPA Name:</th>
<th>Date Submitted:</th>
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**Report for Month of:** 
Submitted by: 

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Member ID</th>
<th>Facility Name</th>
<th>Attending Physician</th>
<th>Reason for Admit (deconditioning, IVABX, wd care, etc.)</th>
<th>Admission/Enrollment Date</th>
<th>Last Covered Date (LCD)</th>
<th>Total SNF Days (Include past &amp; present days)</th>
<th>Prior Residence</th>
<th>Is Member at risk for custodial care? Why?</th>
<th>Member Remains Skilled or Custodial</th>
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*Legend:*
- BC = Board & Care
- GH = Group Home
- LA = Live Alone
- AL = Assisted Living
- HL = Homeless
- SNF = Skilled Nursing Facility
Long Term Care (LTC) Follow-up Review Form

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

**Name (Last, First, M.I.):**

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<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/hrmo</th>
<th>#hrs/month:</th>
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</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:

**CONTINUED CARE NEEDS**

**Resident Care Needs** (Check all conditions that apply):

- □ Chemo
- □ Eloper/Wanderer
- □ Ileostomy
- □ O2
- □ Trach

**Activity Level**

- Bed Mobility
- Supine to Sit
- Sit to Supine

**Indicate all appropriate assistive device(s) Member uses:**

- □ Wheelchair
- □ Cane
- □ Walker
- □ Other

**Treatment Goals Set:**

**Treatment Goals Met:**

**Comments/ Other (e.g. Specialty Consultation):**

**Updates to Discharge Plan:**

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<thead>
<tr>
<th>Date of Review</th>
<th>Nurse Reviewer Printed Name</th>
<th>Nurse Reviewer Signature</th>
<th>Contact Phone Number</th>
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</table>
**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.

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<th>Name (Last, First, M.I.)</th>
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<td><strong>Level 1</strong></td>
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<td><strong>Custodial</strong></td>
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<td><strong>DCP:</strong></td>
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<td><strong>Current Barriers to DCP:</strong></td>
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<td><strong>Treatment Goals:</strong></td>
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<td><strong>Family Training Goals:</strong></td>
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<td><strong>Does Member Have an Advance Directive or Living Will?</strong></td>
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<td><strong>DPOA:</strong></td>
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<td><strong>Does SNF Facility Provide Transportation?</strong></td>
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<td><strong>Indicate Transportation Needs:</strong></td>
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<th>PERSONAL SAFETY &amp; ACTIVITY LEVEL</th>
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<td><strong>Resident Care Needs</strong> (Check all conditions that apply):</td>
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<td><strong>Dietary Requirements/ Restrictions:</strong></td>
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<td><strong>Personal Safety</strong></td>
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<td><strong>Does Member have stairs at home?</strong></td>
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<td><strong>Does Member experience frequent falls?</strong></td>
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<td><strong>Does Member have vision or hearing loss?</strong></td>
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<td><strong>Indicate all appropriate assistive device(s) Member uses:</strong></td>
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<td><strong>Ambulation</strong> x ft.</td>
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<td><strong>Safety/Balance</strong></td>
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<td><strong>Prior Level of Functioning:</strong></td>
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<td><strong>Current Level of Functioning:</strong></td>
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<td><strong>Discharge Plan:</strong></td>
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<th>MEDICATIONS (EXCLUDING PRN) PLEASE INCLUDE SEPARATE SHEET, IF NECESSARY.</th>
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<td><strong>Name the Drug(s):</strong></td>
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<td><strong>Strength:</strong></td>
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<td><strong>Frequency Taken:</strong></td>
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<th>Nurse Reviewer Printed Name</th>
<th>Nurse Reviewer Signature</th>
<th>Contact Phone Number</th>
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Inland Empire Health Plan
Pre-Contractual Audit Tool 2014
Audit Preparation Instructions
Medicare

The following standard forms should be complete and available at the time of the audit and are included in this packet:
- Biographical Information
- Sub-Contracted Service by Facility/Agency

Prepare for the audit by having the following information available:
- All sections of the DOA tool documented with road mapping instructions for each element
- Organizational chart(s)
- Current job descriptions as relevant to audit
- Delegation agreements with any sub-delegated provider

The following is a list of items needed to prepare for the Offsite and Onsite audit.

### Quality Management

- Program, Plan and Description (Desk Review)*
- Committee meeting minutes from last 12 months to include agenda, sign-in sheet (attendance) and signed confidentiality statement: (Desk Review or On-site Review)*:
  - Quality Improvement Committee, and
  - Subcommittee
- Annual Work Plan (Desk Review)*
- Annual QM Program Evaluation (Desk Review)*
- Semi-Annual Reports for Health Plan (Desk Review)*
- Standards of Medical Care Access Policy and Procedure (Desk Review)*

### Utilization Management

- Program, Plan and Description (Desk Review)*
- Policies and procedures (Desk Review)*
- Committee minutes from last 12 months: (On-site Review)
  - Board of Directors
  - Utilization Management Committee, and
  - Subcommittee meeting minutes
- Annual Inter-Rater Reliability Audit (On-site Review)
- Two examples that demonstrate the use of Board Certified consultants to assist with determinations (On-site Review)
- Annual UM Program Evaluation (Desk Review)*
Inland Empire Health Plan
Pre-Contractual Audit Tool 2014
Audit Preparation Instructions

Medicare
- Criteria for Length of Stay and Medical Necessity used during the past 2 years (On-site Review)
- 20 approved pre-certification requests with all required attachments (On-site Review)
- 20 denied requests with all required attachments (On-site Review)
- Evidence that the Affirmative Statement has been distributed to providers and employees who make UM decisions (On-site Review)
- Evidence, other than via a denial letter, that the providers have been notified that they may contact a physician reviewer to discuss denial decisions (Desk or On-site Review)*
- Provider communications from last 12 months (On-site Review)
- Semi-Annual Reports for last 12 months (Desk Review)*
- Evidence of current license for Providers and Employees (RN, LVN) who make UM Decisions (On-site Review)

Care Management
- Applicable policies and procedures (Desk Review)*
- Complex Case Management Policy and Procedure (Desk Review)*
- CM and CCS logs that reflect evidence that the Member has received care management services (On-site Review)
- 5 randomly pulled CM files with care plans (On-site Review)
- 5 randomly pulled CCM files with care plans (On-site Review)
- 5 randomly pulled CCS files (On-site Review)

Credentialing
- Policies and procedures (Desk Review)*
- Committee meeting minutes from last 12 months: (On-site Review)
  - Board of Director
  - Quality Management Committee minutes
  - Credentialing Committee minutes
  - Peer Review Committee minutes
- Credentialing Files – 25 randomly selected files including PCP, Specialists, Mid-Levels and Urgent Care Providers (On-site Review)
- Re-credentialing Files – 25 randomly selected files including PCP, Specialists, Mid-Levels and Urgent Care Providers (On-site Review)
- Practitioner files of those terminated for quality issues (On-site Review)
- Practitioner files that have appealed a decision (On-site Review)
- Home Health files (On-site Review)
Inland Empire Health Plan
Pre-Contractual Audit Tool 2014
Audit Preparation Instructions

Medicare

- Skilled Nursing files (On-site Review)
- Laboratory files (On-site Review)
- Free Standing Surgical Center Files (On-site Review)
- Medical Office Site Review worksheets, tools and summaries (On-site Review)
- Medical Record worksheets, tools and summaries (On-site Review)
- Credentialing delegation data, if applicable (On-site Review)
- Health Delivery Organization Tracking Mechanism for Expirables (On-site Review)

Member Communications Marketing (If Applicable)

- All Member Communication for Marketing, Enrollment, and Disenrollment (Desk Review)*

Claims

- Policies and procedures (Desk Review)*
- Contracts Boilerplate for: (Desk Review)*
  - PCPs
  - Specialists
  - Ancillary Providers
  - Hospitals
- Blinded Claims Sample: (Desk Review)*
  - 15 Paid (Details Attached)
  - 5 Denied (Details Attached)
  - 5 Redetermined (Details Attached)
  - 5 Reconsidered (Details Attached)
- Sample Reports and Logs: (Desk Review)*
  - Paid Claims (Details Attached)
  - Denied Claims (Details Attached)
  - Redetermined Claims (Details Attached)
  - Reconsidered Claims (Details Attached)
  - Pended Claims (Details Attached)
  - Open Claims/Inventory (Details Attached)
  - Overpayments (Details Attached)
  - Check Mailing Attestation Log (Details Attached)
  - Redirected Claims (Details Attached)
- Claims Processing Systems Review (On-site Review)
- Operational Review (On-site Review)
Inland Empire Health Plan
Pre-Contractual Audit Tool 2014
Audit Preparation Instructions

Medicare

<table>
<thead>
<tr>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Compliance Policies and procedures <em>(Desk Review)</em></td>
</tr>
<tr>
<td>• Fraud, Waste and Abuse Policies and procedures <em>(Desk Review)</em></td>
</tr>
<tr>
<td>• HIPAA Policies and procedures <em>(Desk Review)</em></td>
</tr>
</tbody>
</table>

Note: * - Denotes items to be sent to IEHP for desk review prior to the audit.
<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>IPA decision date</th>
<th>Requesting Provider</th>
<th>Requested Provider</th>
<th>Requested Prov Specialty</th>
<th>Referral decision*</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

*Acuity of Referral: Emergent, Urgent, or Routine
**Decision: Approved, Modified, or Denied

Revised 01/2017
## Request for UM Criteria Log

**Legend:**
- **F** = Fax
- **EM** = Email
- **GM** = Ground

### INLAND EMPIRE HEALTH PLAN
### REQUEST FOR UM CRITERIA LOG

<table>
<thead>
<tr>
<th>Date Requested</th>
<th>Date Sent</th>
<th>Sent via:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>F = fax</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EM = email</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GM = ground</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of the Requesting Practitioner or Member</th>
<th>Member Name and IEHP ID #</th>
<th>Line of Business (MC, CMC)</th>
<th>Criteria Requested (i.e. InterQual-MRI Brain)</th>
<th>Reason for Request</th>
<th>Medical Necessity</th>
<th>Benefit</th>
<th>Curve-Out</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

**Submitted by:** ____________________________  **Log for Year:** ____________________________

---

**Legend:**
- **F** = Fax
- **MC** = Medi-Cal
- **CMC** = IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)

Revised 07/2015
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>
### 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>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy - Skin Testing for 80 or Fewer Tests</td>
<td>95004 X up to 80</td>
</tr>
<tr>
<td>CARD – EKG (Adult &amp; Peds)</td>
<td>93000</td>
</tr>
<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>
</tr>
<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>GYN – Abnormal Pap Follow-Ups and:</td>
<td>99213-99215 (X 3)</td>
</tr>
</tbody>
</table>

---

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

A Public Entity
<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT Code</th>
</tr>
</thead>
<tbody>
<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 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>
### IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan)
#### Standing Referral / Extended Access Referral to Specialty Care Request

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Plan</td>
<td></td>
</tr>
<tr>
<td>Date of Request</td>
<td></td>
</tr>
<tr>
<td>IPA/MG</td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td></td>
</tr>
<tr>
<td>Phone #</td>
<td>Phone #</td>
</tr>
<tr>
<td></td>
<td>FAX</td>
</tr>
<tr>
<td>Requesting MD</td>
<td>Phone #</td>
</tr>
<tr>
<td></td>
<td>FAX</td>
</tr>
<tr>
<td>Other Insurance</td>
<td>Phone #</td>
</tr>
<tr>
<td>Member Name</td>
<td>DOB / / M F Phone #</td>
</tr>
<tr>
<td>Address</td>
<td>City State ZIP</td>
</tr>
<tr>
<td>Member ID #</td>
<td></td>
</tr>
<tr>
<td>Eligibility Reviewed Thru</td>
<td>Medi-Cal AEVS Confirmation #</td>
</tr>
<tr>
<td>Policy/Group #</td>
<td></td>
</tr>
<tr>
<td>Referral To (Physician Name):</td>
<td>Type of Specialist:</td>
</tr>
<tr>
<td></td>
<td>Phone #</td>
</tr>
<tr>
<td></td>
<td>FAX</td>
</tr>
<tr>
<td>Diagnosis Primary</td>
<td>ICD 10</td>
</tr>
<tr>
<td>Diagnosis Secondary</td>
<td>ICD 10</td>
</tr>
<tr>
<td><strong>Practitioner Treatment Plan</strong></td>
<td>(Complete or attach)</td>
</tr>
<tr>
<td># Visits/Period</td>
<td>Visits/3 Months</td>
</tr>
<tr>
<td>Time Requested (fill in number of visits)</td>
<td></td>
</tr>
</tbody>
</table>

Reviewed 07/2013
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.

<table>
<thead>
<tr>
<th>REVIEW COMMITTEE USE ONLY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Does diagnosis meet the criteria of long term, life threatening, degenerative, disabling disease or complex medical condition?</td>
</tr>
<tr>
<td>• Is specialist in the plan network?</td>
</tr>
<tr>
<td>If out of network, is contract between plan and specialist obtained?</td>
</tr>
<tr>
<td>Date____________________</td>
</tr>
<tr>
<td># Visits/Period of Time:____________________________</td>
</tr>
</tbody>
</table>

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.

Reviewed 07/2013
## Utilization Management Timeliness Standards

### Centers for Medicare and Medicaid Services (CMS)

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision</th>
<th>Notification Timeframes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Initial Organization Determination (Pre-Service)</strong>&lt;br&gt;- If No Extension Requested or Needed</td>
<td>As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.</td>
<td>Within 14 calendar days after receipt of request.  &lt;br&gt;• Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.</td>
</tr>
<tr>
<td><strong>Standard Initial Organization Determination (Pre-Service)</strong>&lt;br&gt;- If Extension Requested or Needed</td>
<td>May extend up to 14 calendar days.  &lt;br&gt;Note: Extension allowed only if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions must not be used to pend organization determinations while waiting for medical records from contracted providers.</td>
<td>• Use the MA-Extension: Standard &amp; Expedited to notify member and provider of an extension.  &lt;br&gt;<strong>Extension Notice:</strong>  &lt;br&gt;• Give notice in writing within 14 calendar days of receipt of request. The extension notice must include:  &lt;br&gt;1) The reasons for the delay  &lt;br&gt;2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension.  &lt;br&gt;Note: The Health Plan must respond to an expedited grievance within 24 hours of receipt.  &lt;br&gt;<strong>Decision Notification After an Extension:</strong>  &lt;br&gt;• Must occur no later than expiration of extension. Use NDMC template for written notification of denial decision.</td>
</tr>
<tr>
<td><strong>Expedited Initial Organization Determination</strong>&lt;br&gt;- If Expedited Criteria are not met</td>
<td>Promptly decide whether to expedite – determine if:&lt;br&gt;1) Applying the standard timeframe could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function, or 2) If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member’s request for an expedited decision.&lt;br&gt;If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies:&lt;br&gt;• Automatically transfer the request to the standard timeframe.  &lt;br&gt;• The 14 day period begins with the</td>
<td>If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member’s rights followed by written notice within 3 calendar days of the oral notice.  &lt;br&gt;• Use the MA Expedited Criteria Not Met template to provide written notice. The written notice must include:&lt;br&gt;1) Explain that the Health Plan will automatically transfer and process the request using the 14-day timeframe for standard determinations;&lt;br&gt;2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization’s decision not to expedite the determination;&lt;br&gt;3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician’s support indicating that</td>
</tr>
<tr>
<td>Type of Request</td>
<td>Decision</td>
<td>Notification Timeframes</td>
</tr>
<tr>
<td>-----------------</td>
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<td>------------------------</td>
</tr>
<tr>
<td><strong>Expedited Initial Organization Determination</strong></td>
<td>As soon as medically necessary, within 72 hours after receipt of request (includes weekends &amp; holidays).</td>
<td>Within 72 hours after receipt of request.</td>
</tr>
<tr>
<td>- If No Extension Requested or Needed</td>
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<tr>
<td></td>
<td></td>
<td><strong>Approvals</strong></td>
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<tr>
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<td></td>
<td>– Oral or written notice must be given to member and provider within 72 hours of receipt of request.</td>
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<tr>
<td></td>
<td></td>
<td>– Document date and time oral notice is given.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– If written notice <strong>only</strong> is given, it must be <strong>received</strong> by member and provider within 72 hours of receipt of request.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Denials</strong></td>
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<tr>
<td></td>
<td></td>
<td>– When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Document date and time of oral notice.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– If only written notice is given, it must be <strong>received</strong> by member and provider within 72 hours of receipt of request.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Use NDMC template for written notification of a denial decision.</td>
</tr>
</tbody>
</table>

---

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

ICE CMS UM TAT Final 12/02/02
Revised & Approved 6/5/03, 5/17/04, 7/14/04, 4/26/06, 9/13/07, 6/10/11
<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision</th>
<th>Notification Timeframes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expedited Initial Organization Determination</td>
<td>May extend up to 14 calendar days.</td>
<td>Use the MA-Extension: Standard &amp; Expedited template to notify member and provider of an extension.</td>
</tr>
</tbody>
</table>
| - If Extension Requested or Needed                   | **Note:** Extension allowed *only* if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions **must not** be used to pend organization determinations while waiting for medical records from contracted providers. When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request). Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely. | **Extension Notice:**  
  - Give notice in writing, within 72 hours of receipt of request. The extension notice must include:  
    1) The reasons for the delay  
    2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension.  
  **Note:** The Health Plan must respond to an expedited grievance within 24 hours of receipt.  
  **Decision Notification After an Extension:**  
  - **Approvals**  
    - Oral or written notice must be given to member and provider no later than upon expiration of extension.  
    - Document date and time oral notice is given.  
    - If written notice only is given, it must be received by member and provider no later than upon expiration of the extension.  
  - **Denials**  
    - When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice.  
    - Document date and time of oral notice.  
    - If only written notice is given, it must be received by member and provider no later than upon expiration of extension.  
    - Use NDMC template for written notification of a denial decision. |
<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision</th>
<th>Important Message from Medicare (IM)</th>
<th>Detailed Notice of Discharge (DND)</th>
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</table>
| Hospital Discharge Appeal Notices       | Attending physician must concur with discharge decision from inpatient hospital to any other level of care or care setting. Continue coverage of inpatient care until physician concurrence obtained. | Hospitals must issue the IM within 2 calendar days of admission, obtain the signature of the member or representative and provide a copy of the IM at that time. Hospitals must issue a follow up IM not more than 2 calendar days prior to discharge from an inpatient hospital.  
  - NOTE: Follow up copy of IM is not required:  
    - If initial delivery and signing of the IM took place within 2 calendar days of discharge.  
    - When member is being transferred from inpatient to inpatient hospital setting.  
    - For exhaustion of Part A days, when applicable.  
If IM is given on day of discharge due to unexpected physician order for discharge, member must be given adequate time (at least several hours) to consider their right to request a QIO review. |
| (Concurrent)                            | Health Plans or delegates are responsible for delivery of the Detailed Notice of Discharge (DND) when a member appeals a discharge decision. DND must be delivered as soon as possible but no later than noon of the day after notification by the QIO (Quality Improvement Organization). | Upon notification by the QIO that a member or representative has requested an appeal, the Health Plan or delegate must issue the DND to both the member and QIO as soon as possible but no later than noon of the day after notification by the QIO. The DND must include:  
  - A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered.  
  - A description of any applicable Medicare coverage rules, instructions, or other Medicare policy, including information about how the member may obtain a copy of the Medicare policy from the MA organization.  
Any applicable Medicare health plan policy, contract provision, or rationale upon which the discharge determination was based.  
- Facts specific to the member and relevant to the coverage determination sufficient to advise the member of the applicability of the |
### Type of Request

#### Decision

- **Important Message from Medicare (IM)**
- **Detailed Notice of Discharge (DND)**
  - coverage rule or policy to the member’s case.
  - Any other information required by CMS.

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<tr>
<th>Type of Request</th>
<th>Decision</th>
<th>Notice of Medicare Non-Coverage (NOMNC) Notification</th>
<th>Detailed Explanation of Non-Coverage (DENC) Notification</th>
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<tr>
<td><strong>Termination of Provider Services:</strong></td>
<td>The Health Plan or delegate is responsible for making the decision to end services no later than two (2) calendar days or 2 visits before coverage ends:</td>
<td>The SNF, HHA or CORF is responsible for delivery of the NOMNC to the member or authorized representative:</td>
<td>Upon notification by the Quality Improvement Organization (QIO) that a member or authorized representative has requested an appeal:</td>
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<tr>
<td>- Skilled Nursing Facility (SNF)</td>
<td></td>
<td>- The NOMNC must be delivered no later than 2 calendar days or 2 visits prior to the proposed termination of services and must include: member name, delivery date, date that coverage of services ends, and QIO contact information.</td>
<td>- The Health Plan or delegate must issue the DENC to both the QIO and member no later than close of business of the day the QIO notifies the Health Plan of the appeal.</td>
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<tr>
<td>- Home Health Agency (HHA)</td>
<td></td>
<td>- A determination that such services are no longer medically necessary</td>
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<td>- Comprehensive Outpatient Rehabilitation Facility (CORF)</td>
<td>OR</td>
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<td><strong>NOTE:</strong> This process does not apply to SNF Exhaustion of Benefits (100 day limit).</td>
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**Note:** Check with Health Plan or delegate for delegated responsibility, as a Health Plan or delegate may choose to deliver the NOMNC instead of the provider.