14. UTILIZATION MANAGEMENT

A. Review Procedures

1. Primary Care Provider Referrals

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members and Providers.

POLICY:

A. Primary Care Providers (PCPs) are responsible for supervising, coordinating, and providing initial primary care to patients; for initiating referrals; and for maintaining the continuity of patient care.

B. IEHP and its Delegates must have a referral system to track and monitor referrals requiring prior authorization through the program of Utilization Management program oversight. See Policy 25E1, "Utilization Management – Delegation and Monitoring."

DEFINITIONS:

A. Delegate – A health plan, medical group, IPA or any contracted organization delegated to provide utilization management services.

PROCEDURES:

A. Referrals to Specialists, second opinions, elective Hospital admissions, diagnostic tests, or any other medically necessary services, which require prior authorization are initiated by PCPs or Specialists through their IPA. This process involves utilizing information such as medical records, test reports, specialist consults, and verbal communication with the requesting Provider. See Policy 14D, "Pre-Service Referral Authorization Process."

   1. Providers must submit urgent preservice and urgent concurrent referrals within 24-hours of the determination that the referral is necessary.

   2. For non-urgent preservice or concurrent referrals, Providers have two (2) working days from the determination that a referral is necessary, to submit the referral and all supporting documentation.

   3. Providers 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.

B. Determinations must be made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Providers. See Policy 25E1, "Utilization Management – Delegation and Monitoring."

C. Copies of referrals and any received consultations and/or service reports must be filed in the Member's medical record.

   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 Specialist reports, documents their review in the Member's medical record, and formulates a follow-up care plan for the Member if applicable. 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 reviewed during Facility Site Review and Medical Record Review Survey, Interim Audits, and/or Focused Audits, or as required in accordance with Policy 7A, "PCP and IPA Medical Record Requirements."

D. PCPs must maintain a Referral Tracking Log or another referral tracking system for all referrals submitted for approval to IEHP or their IPA. PCPs must utilize this log to coordinate care for the Member and to obtain assistance from IEHP or their IPA if specialty appointments are delayed, or consultation notes are not received.

E. The PCP may use either the PCP Referral Tracking Log (see Attachment, "PCP Referral Tracking Log" in Section 14) or another system that contains the following required information:

1. Date of service;
2. Date the referral was sent to IPA & name of the IPA;
3. Member's name and date of birth;
4. Acuity of referral (routine or urgent);
5. Reason for referral/diagnosis;
6. Service or activity requested;
7. Date the authorization was received;
8. Referral decision (approved or denied/partially approved (modified);
9. Date the patient was notified (PCP must direct the Member to the Specialist within four (4 business days of the approval or partial approval (modification));[1]
10. Date of appointment or service;
11. Date the consult report was received; and
12. Outreach efforts (dates of when outreach was attempted).

F. The PCP Referral Tracking Log or equivalent must always be available at the PCP site. This is reviewed during Facility Site Review and Medical Record Review Survey, Interim Audits, and/or Focused Audits, or as required in accordance with Policy 7A, "PCP and IPA Medical Record Requirements."

CA Health & Saf. Code § 1374.16(c)

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

H. For referrals for behavioral health services, please see policies 12D1, “Behavioral Health - Behavioral Health Services” and 12D2, “Behavioral Health - Alcohol and Drug Treatment Services.”

I. Monitoring and Oversight

1. IEHP oversees and monitors the PCP referral process through referral audits. IEHP monitors sites for referral issues using both internal quality management systems and external sources of information. Quality monitoring is performed through review of the following (at minimum): Grievance data, Potential Quality Incident (PQI) referrals, focused reviews when necessary, and Facility Site Review (FSR)/Medical Record Review (MRR) processes. See Policy 6A, “Facility Site Review and Medical Record Review Survey Requirements and Monitoring.”

2. If a PCP is identified as deficient through the FSR/MRR process (Office Management E1 or E2) IEHP will follow-up with the PCP for a focused audit and referral training assigned by the Quality Management Coordinator and scheduled by the Quality Management (QM Nurse).

3. IEHP will also issue a Corrective Action Plan (CAP) the same day the audit is performed (See Attachments, “Referral Audit Corrective Action Plan Tool” and “Referral Audit CAP Notification Letter” in Section 14).

INLAND EMPIRE HEALTH PLAN		
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APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. IEHP and its IPAs are required to establish and implement procedures for Primary Care Providers (PCPs) to request a standing referral to a Specialist or specialty care center 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.[1]

B. PCPs are responsible for supervising, coordinating, and providing initial and primary care to the Members; for initiating referrals; and for maintaining continuity of care.

PROCEDURES:

A. Practitioners that are Board-eligible in appropriate specialties, e.g., Infectious Disease, can 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 Providers in IEHP's Provider network by:

   1. Contacting IEHP Member Services Department at (877) 273-4347 or TTY (800) 718-4347; or

   2. Accessing Doctor Search online at www.iehp.org.

B. Any medical condition requiring frequent or repeat visits to a Specialist should be considered for standing referral or extended access, if the Member requests or the PCP and Specialist determine that continuing care is required.

C. 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;

[1] California Health and Safety Code (Health & Saf. Code) § 1374.16

6. Rehab for major trauma;
7. Neurological conditions such as multiple sclerosis and uncontrollable seizures among others; and
8. Gastrointestinal (GI) conditions such as severe peptic ulcer and chronic pancreatitis among others.

D. 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.

E. The standing referral request must be submitted and processed as follows:

1. The PCP submits the request for standing referral to the Member's IPA using the designated form (See Attachment, "Standing Referral and Extended Access Referral to Specialty Care" in Section 14).
2. Within three (3) business days of receiving this request, IEHP or the IPA must:[2]
   a. Consult with the PCP, Specialist (if any) and/or Member to ascertain the need for continuing care with the Specialist;
   b. Approve a treatment plan (if necessary to describe the course of care); and
   c. Make a determination to approve, deny or partially approve (modify) the standing referral request. Determinations must be made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Providers. See Policy 25E1, "Utilization Management – Delegation and Monitoring."

[2] CA Health & Saf. Code § 1374.16(c)

3. The PCP must direct the Member to the Specialist within four (4) business days of the approval or partial approval (modification).[3]

F. IPAs can require Specialists to provide to the PCP and the IPA written reports of care provided under a standing referral.

G. 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.[4] When authorizing a standing referral to a Specialist for purposes of having that Specialist coordinate the care of a Member, who is infected with HIV, the Member must be referred to an HIV/AIDS Specialist.[5]

Out of Network

A. IEHP and its IPAs are not required to refer Members to out-of-network practitioners unless the appropriate specialty care is not available within the network.[6]

B. IEHP and its IPAs must cover any out-of-network services adequately and timely when such services are medically necessary and not available within the network.

C. IEHP and its IPAs are not required to refer Members to an out-of-network HIV/AIDS specialist unless an appropriate HIV/AIDS specialist, or qualified nurse practitioner, or physician assistant under the supervision of an HIV/AIDS specialist is not available within the network, as determined by the IPA in conjunction with IEHP's Chief Medical Officer or designee.[7]

INLAND EMPIRE HEALTH PLAN			
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[3] CA Health & Saf. Code § 1374.16(c)
[4] Title 28, California Code of Regulations § 1300.74.16(f)
[5] Ibid.
[6] CA Health & Saf. Code § 1374.16(d)
[7] 28 CCR § 1300.74.16(g)

14. UTILIZATION MANAGEMENT

B. Second Opinions

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. IEHP and its IPAs provide for Members second opinion from a qualified health professional within the network at no cost to the Member or arranges for the Member to obtain a second opinion outside of the network if services are not available within the network.[1]

PROCEDURES:

Requesting Second Opinion

A. Primary Care Providers (PCPs), Specialists and Members or their representative may request a second opinion from their IPA regarding proposed medical or surgical treatments from an appropriately qualified participating healthcare professional.

B. Members may 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 their IPA to request a second opinion.

C. Second opinions are authorized and arranged through the Member's IPA. The PCP or Specialist submits the request for a second opinion to the Member's IPA including documentation of the Member's condition and proposed treatment.

Timeframes

A. Determinations must be made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Providers. See Policy 25E1, "Utilization Management Delegation and Monitoring."

B. In cases where the Member faces an imminent and serious threat to their 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 the Member and Provider are completed within seventy-two (72) hours of receiving the request, whenever possible.[2]

Authorizing Second Opinion Requests

A. Reasons for providing or authorizing a second opinion include, but are not limited to, the following:[3]

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

[1] California Health and Safety Code (Health & Saf. Code) § 1383.15
[2] CA Health & Saf. Code § 1383.15(c)
[3] CA Health & Saf. Code § 1383.15(a)

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 Provider 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 of the treatment; and
5. The Member has attempted to follow the plan of care or consulted with the initial Provider concerning serious concerns about the diagnosis or plan of care.

B. If the Member is requesting a second opinion about care received from their PCP, the second opinion must be provided by an appropriately qualified Provider of the Member's choice within the IPA's network.[4]

C. If the Member is requesting a second opinion about care received from a Specialist, the second opinion must be provided by any Provider with the same or equivalent specialty of within the IPA's network. [5]

D. If there is not a Provider within the IPA's network that meets the qualifications for a second opinion, the IPA must authorize a second opinion by a qualified Provider outside its network.[6]

E. IEHP and its IPAs must provide and coordinate any out-of-network services adequately and timely, including but not limited to making arrangements for transportation.[7] Please see Policy 9G, "Non-Emergency Medical and Non-Medical Transportation Services."

F. IEHP and its IPAs require the second opinion Provider to provide the Member and initial Provider consultation reports, including any recommended procedures or tests that the second opinion Provider believes appropriate.[8] Consultation reports must be provided as expeditiously as the Member's condition requires, but not to exceed two (2) weeks of a non-urgent visit or twenty-four (24 hours) of an urgent visit.

G. 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 Behavioral health and Care Management Department through the secure IEHP Provider portal as expeditiously as the Member's condition requires, but no later than two (2) weeks of a non-urgent visit or twenty-four (24) hours of an urgent visit. BH Providers can receive training

[4] CA Health & Saf. Code § 1383.15(e)
[5] CA Health & Saf. Code § 1383.15(f)
[6] CA Health & Saf. Code § 1383.15(g)
[7] Ibid.
[8] CA Health & Saf. Code § 1383.15(h)

on how to use the secure IEHP Provider portal or how to complete the provider web forms by calling the IEHP Provider Relations Team at (909) 890-2054 or emailing providerservices@iehp.org.

H. The IPA is responsible for providing a copy of all approvals, and denial notification letters of second opinions to the PCP.

I. The notification to the Practitioner that is performing the second opinion must include the timeframe and requirements for completion and submission of the consultation report.

J. A request for second opinion may only be denied if the Member insists on an out-of-network provider when there is an appropriately qualified Provider in-network. If the request for second opinion is denied the IPA provides written notification to the Member, including the rationale for the denial or alternative care recommendations and information on how to appeal this decision.[9]

K. Members disagreeing with the denial of their request for second opinion may appeal through the IEHP Appeal process. Refer to Section 16, "Grievance and Appeal Resolution System" for more information.

Monitoring and Oversight

A. The PCP is responsible for documenting second opinion requests and monitoring receipt of consultation reports on the PCP Referral Tracking Log (See Attachment, "PCP Referral Tracking Log" in Section 14). See Policy 14A1, "Review Procedures – Primary Care Provider (PCP) Referrals."

B. IPAs must utilize a Second Opinion Tracking Log to track the status of second opinion requests and to ensure that the second opinion Provider provides the consultation report within three (3) working days of the visit (See Attachment, "Second Opinion Tracking Log" in Section 25). See Policy 25E2, "Utilization Management - Reporting Requirements."

C. IEHP or the IPA's Medical Director may request a second opinion at any time if it is felt to be necessary to support a proposed method of treatment or to provide recommendations for an alternative method of treatment.

INLAND EMPIRE HEALTH PLAN			
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[9] CA Health & Saf. Code § 1383.15(i)

14. UTILIZATION MANAGEMENT

C. Emergency Services

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. Prior authorization is not required for emergency care, as defined in this policy.[1] Providers must render services to Members who present themselves to an Emergency Department (ED) for treatment of an emergent medical and behavioral condition. Per federal law, at a minimum, services must include a Medical Screening Exam (MSE).

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.

DEFINITIONS:

A. Emergency medical condition - 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:[2, 3,4]

   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;
   2. Serious impairment to bodily function; or
   3. Serious dysfunction of any bodily organ or part.

B. Psychiatric emergency – A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:[5]

   1. An immediate danger to himself or herself or to others; or
   2. Immediately unable to provide for or utilize food, shelter, or clothing due to the mental disorder.

C. Emergency services – Covered inpatient and outpatient services that are furnished by a Provider qualified to furnish such services and that are needed to evaluate or stabilize a Member's emergency medical condition.[6]

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[1] Medicare Managed Care Manual, "Benefits and Beneficiary Protections," Section 20.3
[2] Title 42, Code of Federal Regulations (CFR) § 438.114
[3] California Health and Safety Code (Health & Saf. Code) § 1317.1(b)
[4] Medicare Managed Care Manual, "Benefits and Beneficiary Protections," Section 20.2
[5] CA Health & Saf. Code § 1317.1(k)
[6] Medicare Managed Care Manual, "Benefits and Beneficiary Protections," Section 20.2

D. Post-stabilization services – Services related to an emergency medical condition that are provided after a Member is stabilized to maintain the stabilized condition, or are provided, to improve or resolve the condition.[7]

PROCEDURES:

A. Healthcare professionals 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.[8]

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

C. The IPA's payment for associated services must be based on the Member's presentation and the complexity of the medical decision-making, as outlined in the American Medical Association (AMA) Current Procedural Terminology (CPT) Guide under 'Emergency Department Services'.

D. If it is determined that the Member's condition was not emergent, the Member's IPA is responsible for the MSE, at a minimum based on individual contracts. The Member is not financially responsible and must not be billed for any difference between the amount billed by the Hospital and amount paid by the IPA.

Post-Stabilization Care

A. The attending emergency physician or treating Provider is responsible for determining when the Member is sufficiently stabilized for transfer or discharge.[9]

B. IEHP ensures that a physician is available twenty-four (24) hours a day, seven (7) days a week to authorize medically necessary post-stabilization care and coordinate the transfer of stabilized Members in an ED, if necessary.

C. IEHP and its IPAs shall make every effort to respond to requests for necessary post-stabilization medical care within one (1) hour of receipt.

D. IEHP or the IPA is financially responsible for post-stabilization care in the event they:[10]

1. Do not respond to a request for pre-approval within the timeframe allotted;
2. Cannot be contacted; or

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[7] Medicare Managed Care Manual, "Benefits and Beneficiary Protections," Section 20.5.1
[8] https://www.aafp.org/afp/2007/0601/p1679.html
[9] Medicare Managed Care Manual, "Benefits and Beneficiary Protections," Section 20.4
[10] Medicare Managed Care Manual, "Benefits and Beneficiary Protections," Section 20.5.2

3. Cannot reach an agreement with the treating Provider concerning the Member's care and IEHP or IPA physician is not available for consultation.

All subsequent days are subject to review for medical necessity.

E. If IEHP or the IPA is unable to reach an agreement with the attending emergency physician regarding the Member's care, the attending emergency physician may continue with care for the Member until an IEHP or IPA physician is able to be consulted and one of the following criteria is met:[11]

1. An IEHP or IPA physician with privileges at the emergency physician's hospital assumes responsibility for the Member's care;
2. An IEHP or IPA physician assumes responsibility for the Member's care through transfer;
3. The IEHP or IPA physician and the attending emergency physician are able to reach an agreement concerning the Member's care; or
4. The Member is discharged.

F. All requests for authorization of post-stabilization care services must be documented by IEHP or the IPA along with any responses to such requests. Documentation includes, but is not limited to, the date and time of the request, the name of the requesting Provider, and the name of the IEHP or IPA representative responding to the request.

G. IEHP has the authority to deny payment for the delivery of post-stabilization medical care or the continuation of delivery of such care if clinical documentation is not received timely.

H. If IEHP or its IPA denies the request for authorization of post-stabilization medical care and elects to transfer the Member to another health care provider, IEHP informs the provider of the health plan's decision and coordinates the transfer of the Member.[12]

I. IPAs are encouraged to develop contractual arrangements with EDs and physician groups.

J. IEHP provides non-contracted facilities in the State of California with specific contact information needed to obtain timely authorization of post-stabilization care for Members.[13]

INLAND EMPIRE HEALTH PLAN			
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[11] Medicare Managed Care Manual, "Benefits and Beneficiary Protections," Section 20.5.3
[12] Title 28, California Code of Regulations (CCR) § 1300.71.4(b)
[13] CA Health & Saf. Code § 1262.8(j)

14. UTILIZATION MANAGEMENT

D. Pre-Service Referral Authorization Process

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. IEHP and its Delegates have policies and procedures that establish the process by which they prospectively, retrospectively, or concurrently review and approve, partially approve (modify), or deny, based in whole or in part on medical necessity, services requested by Providers for Members. These policies and procedures ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes.[1]

B. Primary Care Providers (PCPs) are responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care.

DEFINITIONS:

A. Delegate – A health plan, medical group, IPA, or any contracted organization delegated to provide utilization management services.

PROCEDURES:

Provider Responsibilities

A. 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.
    a. Referrals that are not prioritized are handled as "routine."
    b. 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 (See Policy 14I, "Expedited Initial Organization Determinations");
2. The diagnosis (ICD) and procedure (CPT) codes;
3. Pertinent clinical information supporting the request; and
4. Signature of referring Provider and date. This may consist of handwritten signature, handwritten initials, unique electronic identifier, or electronic signatures that can demonstrate appropriate controls to ensure that only the individual indicated may enter a

[1] California Health and Safety (Health & Saf.) Code § 1367.01

signature.

B. An Advanced Practice Practitioner affiliated with the referring Provider such as a Nurse Practitioner (NP) or Physician Assistant (PA) may sign and date the referral form but must document on the form the name of the referring Provider.

C. The referring Provider must review any referral prior to the submission to the Delegate. If there are questions about the need for treatment or referral, the referring Provider must see the Member prior to submitting the referral to the Delegate.

D. Specialists are required to forward consultation notes to the referring Provider within two (2) weeks of the visit. Copies of referrals and any received consultations and/or service reports must be filed in the Member's medical record. See Policy 14A1, "Primary Care Provider Referrals."

IEHP and Delegate Responsibilities

A. IEHP and its Delegates must allow Members to initiate requests for services.

B. IEHP and its Delegates must inform contracted and non-contracted providers of their referral and prior authorization process at the time of referral. Information must include, at a minimum:

   1. How to submit referrals;
   2. Turnaround timeframes for determinations; and
   3. Services that do not require prior authorization.

C. Prior authorization for proposed services, referrals, or hospitalizations involve the following:

   1. Verification of Member eligibility by the Delegate;
   2. Written documentation by the referring Provider of medical necessity for a service, procedure, or referral;
   3. Verification by the Delegate that the place of service and requested Provider is within the IEHP network;
   4. Assessment of medical necessity and appropriateness of level of care with determination of approval or denial of the proposed service or referral; and
   5. Consulting with the referring Provider, when appropriate.

D. IEHP and its Delegates consistently apply criteria and standards for approving, partially approving (modifying or authorizing an amount, duration or scope that is less than requested), or denying requested services. See Policy 25E1, "Utilization Management – Delegation and Monitoring."

E. IEHP and its Delegates ensure that decisions to deny or partially approve (modify) are made by a qualified health care professional with appropriate clinical expertise in the condition and

disease.[2] Please see Policy 25E1, "Utilization Management – Delegation and Monitoring," for more information.

F. IEHP and its Delegates must have a process that facilitates the Member's access to needed specialty care by issuing a prior authorization of, at a minimum, a consult and up to two (2) follow up visits for medically necessary specialty care. Prior authorization for medically necessary procedures or other services that can be performed in the office, beyond the initial consultation and up to two (2) follow up visits, should be authorized as a set or unit. For example, when approving an ENT consultation for hearing loss, an audiogram should be approved (See Attachment, "Specialty Office Service Auth Sets Grid" in Section 14).

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.

G. Prior authorization is not required, and Member may self-refer for the following services. All other services require prior authorization:

1) Emergency Services (see Policy 14C, "Emergency Services"); [3]

2) Family planning (see Policy 10K, "Family Planning Services");

3) Abortion services (see Policy 9D, "Access to Services with Special Arrangements");

4) Sexually transmitted infection (STI) diagnosis and treatment (see Policy 10G, "Sexually Transmitted Infection (STI) Services");

5) Sensitive and confidential services (see Policy 9D, "Access to Services with Special Arrangements");

6) HIV testing and counseling at the Local Health Department (see Policy 10H, HIV Testing and Counseling");

7) Routine OB/GYN Services, (including prenatal care by Family Care Practitioner (credentialed for obstetrics) within IPA network;

8) Out of area renal dialysis; [4]

9) Biomarker testing for advanced or metastatic stage 3 or 4 cancers;[5]

a) Please visit the United States Food and Drug Administration (FDA) website for a continually updated list of FDA-approved cancer therapies for which associated biomarker tests may be ordered.[6]

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[2] Medicare Managed Care Manual "Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance," Section 40.9.
[3]Medicare Managed Care Manual "Chapter 4 – Benefits and Beneficiary Protections," Section 20.3
[4] Medicare Managed Care Manual "Chapter 4 – Benefits and Beneficiary Protections," Section 110.1.3.
[5] California Health and Safety Code (CA HSC) §1367.665
[6] https://www.accessdata.fda.gov/scripts/cder/daf/

10) Urgent care;

11) Preventative services; and

12) Other services as specified by the CMS.

H. Referrals to out-of-network practitioners require documentation of medical necessity, rationale for the requested out-of-network referral, and prior authorization from the IPA (see Attachment, "Health Plan Referral Form for Out-of-Network and Special Services" in Section 14). Once the prior authorization has been obtained, the PCP's office should assist the Member with making the appointment, continuing to monitor the Member's progress to ensure appropriate intervention, and ensure a safe transition back into the network.

I. Determinations must be made in a timely manner, not to exceed regulatory turnaround timeframes for determination and written notification of Members and Practitioners (see Attachment, "UM Timeliness Standards – IEHP DualChoice" in Section 14).[7] See Policy 25E1, "Utilization Management - Delegation and Monitoring."

J. A Member or Provider who is not able to obtain a timely referral to an appropriate Provider can file a complaint with the Department of Managed Health Care (DMHC):[8]

1. Member complaint line: By phone toll-free at (888)466-2219
   By email at helpline@dmhc.ca.gov

2. Provider complaint line: By phone toll-free at (877)525-1295
   By email at plans-providers@dmhc.ca.gov

K. In the event a Specialist is terminated voluntarily, or as directed by IEHP, the IPA coordinates the redirection of the Members' care as needed.

Monitoring and Oversight

A. IEHP and its IPAs are expected to monitor referrals to identify trends in the following:

1. Potential over or under utilization of Specialists; and
2. Referral requests that are within the scope of practice of the PCP.

B. IEHP and its IPAs shall implement interventions to address identified issues. Interventions include but are not limited to:

1. A written correspondence to the Provider that identifies the concern with supporting policy or contract attached;
2. An outreach from the Medical Director to discuss the concern and educate the Provider; or

3. Any other intervention deemed appropriate by the Medical Director, which may include, but not be limited to, reporting a potential quality of care incident and/or escalating the issue to

[7] Title 42 Code of Federal Regulations (CFR) §§ 438.210, 422.568, 422.570, and 422.572
[8] CA Health & Saf. Code § 1367.01(e)

4. the Peer Review Subcommittee.

INLAND EMPIRE HEALTH PLAN			
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Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

E. Referral Procedure for Custom Wheelchairs and Powered Mobility Devices

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. IEHP and its IPAs ensure that medically necessary Durable Medical Equipment (DME) is provided to Members in a timely manner.[1]

DEFINITIONS:

A. Custom Wheelchair – A custom wheelchair, either manual or power, is one which has been uniquely constructed or assembled to address a Member's individual medical needs for positioning, support and mobility.

B. Qualified Rehabilitation Professional – Professionals with competence in analyzing the needs of consumers with disabilities, assisting in the selection of appropriate assistive technology for the Member's needs, and training in the use of the selected device(s). Specialty certification is required for professionals working in seating, positioning and mobility.

PROCEDURES:

IPA Responsibilities

A. IPAs with Global or Shared Risk are responsible for authorizing custom wheelchair/powered mobility device purchases for their assigned Members. Financial responsibility for repairs and maintenance are outlined in the IPA's contract with IEHP.

B. The IPA must ensure the Member undergoes a thorough functional/safety evaluation performed by an independent third party to determine medical necessity. This evaluation must be performed by a Physiatrist or Qualified Rehabilitation Professional, as authorized by the IPA.

C. The IPA must review requests for custom wheelchair/powered mobility devices that meet Medicare criteria following their prior authorization procedures. Determinations must be made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Providers (See Attachment, "UM Timeliness Standards – IEHP DualChoice" in Section 14). See Policy 25E1, "Utilization Management Delegation and Monitoring" for prior authorization process requirements.

D. If approved, the IPA will arrange for the Member to be assessed by the vendor for a seating evaluation, either facility-based or in-home, to determine the need for custom wheelchairs,

[1] Medicare Managed Care Manual, "Benefits and Beneficiary Protections," Section 10.12

power wheelchairs, non-routine wheelchair therapeutic seat cushions, and/or wheelchair positioning systems.

E. If the IPA determines that the request for custom wheelchair/powered mobility devices does not meet Medicare criteria, the IPA will forward the referral to IEHP for final determination.

1. The IPA must forward the request to IEHP's Utilization Management (UM) department via the secure IEHP Provider Portal, as expeditiously as possible.
2. The referral request must be accompanied with the following, at minimum:
   a. Completed referral form signed by the Member's physician or specialist;
   b. Information about the Member's current equipment, if applicable; and
   c. The results of the functional/safety evaluation as performed by an independent third-party Physiatrist or Qualified Rehabilitation Professional.

IEHP Responsibilities

A. IEHP reviews referral and supporting documentation submitted by the IPA. Final determinations are made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Providers (See Attachment, "UM Timeliness Standards – IEHP DualChoice" in Section 14).

B. If the IPA does not submit a thorough functional/safety evaluation to support the medical necessity of the custom wheelchair/powered mobility device, then IEHP will have the option to obtain a functional/safety evaluation at its discretion and will deduct from the IPA's capitation payment.

C. IEHP will issue a denial letter for forwarded requests that do not meet Medicare or Medi-Cal criteria. If the request meets Medi-Cal criteria, IEHP will authorize the request under the Medi-Cal line of business.

D. If approved, IEHP will arrange for the Member to be assessed by the vendor for a seating evaluation, either facility-based or in-home, to determine the need for custom wheelchairs, power wheelchairs, non-routine wheelchair therapeutic seat cushions, and/or wheelchair positioning systems.

E. Unless otherwise informed, the equipment will be delivered to the Member's home. The vendor will contact the Member and schedule a post-delivery assessment.

INLAND EMPIRE HEALTH PLAN		
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14. UTILIZATION MANAGEMENT

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

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP ensures that Members in need of Long-Term Care (LTC) are placed in a health care facility that provides the level of care most appropriate to their medical needs. These health care facilities include but are not limited to skilled nursing, adult subacute, pediatric subacute, and intermediate care units.

B. The Member's Independent Physician Association (IPA) is financially responsible for professional services rendered during the month of admission and the month after. IEHP is financially responsible for facility services provided during the month of admission and for as long as the Member is enrolled with IEHP.

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 promote the transition of Members back into the community, as appropriate.

DEFINITIONS:

A. Long-Term Care (LTC) – Rehabilitative, restorative and/or ongoing skilled nursing care to patients or residents in need of assistance with activities of daily living.[1]

B. Custodial Care – Consists of non-medical care that can reasonably and safely be provided by non-licensed caregivers and involves help with daily activities like bathing and dressing.[2]

PROCEDURES:

Custodial Level Long-Term Care and Provider Responsibilities

A. Members may be admitted to LTC facilities for custodial care from acute inpatient settings, transition from skilled level, or directly admitted from the community. For information on skilled level LTC, please see Policy 14F2, "Long Term Care – Skilled Level."

[1] Centers for Medicaid and Medicare Services (CMS), "Custodial Care vs Skilled Care," March 2016. https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/infograph-CustodialCarevsSkilledCare-%5BMarch-2016%5D.pdf

[2] Ibid.

B. For Members directly admitted from the community, the treating Primary Care Provider (PCP) or Specialist must submit a referral to the Member's assigned IPA requesting admission. Determinations must be made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Practitioners (see Attachment, "UM Timeliness Standards – Medi-Cal" in Section 14).[3] See Policy 14D, "Pre-Service Referral Authorization Process."

C. Within 48 hours[4] of the Member's admission, the LTC facility must submit to the IPA all clinical documentation that demonstrate the medical necessity of the inpatient admission. If clinical documents are not received timely, the inpatient admission will be at risk for potential denial.

D. Prior to transferring a Member to a hospital, or before a Member goes on therapeutic leave, the LTC facility must provide written information to the Member or Member's representative that specifies:[5]

   1. That the Member has a right to a seven (7) day bed hold, during which the Member is permitted to return and resume residence.

   2. The LTC facility's policy regarding bed holds, consistent with the following:

      a. If the Member's hospitalization or therapeutic leave exceeds the bed hold period of seven (7) days, but the Member still requires the services provided by the LTC facility and is still eligible for said services, the Member may still return to their previous room if available, otherwise they will be able to return immediately upon the first availability of a bed in a semi-private room.[6]

E. If an LTC facility determines that a Member who was transferred with an expectation of returning to the facility cannot return to the facility, the facility must follow the procedure for discharge in accordance with applicable state and federal requirements.[7]

F. The LTC facility must submit all clinical documentation in advance of, or at the time of the Member's discharge or transfer, and no later than within two (2) business days post-discharge.[8] If clinical documentation is not received timely, IEHP will issue a denial of payment to the facility due to lack of clinical documentation supporting medical necessity.

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[3] Title 42 Code of Federal Regulations (CFR) §§ 438.210, 422.568, 422.570, and 422.572
[4] Department of Managed Health Care (DHCS) CalAIM Dual Eligible Special Needs Plans (D-SNP) Policy Guide – Chapter 2, Information Sharing Policy
[5] 42 CFR §483.15 (d)
[6] 42 CFR §483.15 (e)(1)
[7] 42 CFR §483.15 (e)(1)(ii)
[8] Ibid.

G. Contracted LTC facilities must use secure methods, including fax, telephone, and/or electronic data record exchange, to inform IEHP of any LTC admission, discharge, or transfer, for all Members.[9]

IEHP, IPA & PCP Responsibilities

A. IPAs are responsible for forwarding to IEHP all requests for custodial LTC upon receipt of the request and indicating whether the request for custodial level LTC is after an acute inpatient admission. These requests shall be forwarded to IEHP's Utilization Management Department via fax at (909) 912-1045.

B. IEHP and its IPAs provide all necessary care coordination for Members in LTC facilities.

C. IEHP will authorize Accommodation Codes as follows:

1. Accommodation codes do not apply to custodial level of care, unless otherwise indicated by IEHP's Medical Director for a limited period of time.
2. All accommodation codes require an authorization within the inpatient authorization.
3. All accommodation codes are approved on a case-by-case basis after review of the supporting clinical documentation.
4. Accommodation code 560 does not apply to the use of alcohol and marijuana.

D. Please refer to the Medi-Cal Provider Manual for information on custodial care under Medi-Cal.

E. PCPs must conduct follow-ups with discharged Members within appropriate timeframes. IEHP provides an Inpatient Discharge roster, accessible through the IEHP Provider Portal landing page, which displays the follow-up due date for Members.

INLAND EMPIRE HEALTH PLAN		
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[9] Ibid.

APPLIES TO:

A. This policy applies for all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP ensures that Members in need of Long-Term Care (LTC) are placed in a health care facility that provides the level of care most appropriate to their medical needs. These health care facilities include, but are not limited to, skilled nursing, adult subacute, pediatric subacute, and intermediate care units.

B. The Member's IPA is financially responsible for professional services rendered during the month of admission and the month after. IEHP is financially responsible for facility services provided during the month of admission and for as long as the Member is enrolled with IEHP.

C. IEHP is responsible for performing all aspects of non-delegated utilization management and care management (CM) responsibilities related to placement in skilled level LTC. IEHP will follow active Members while in a LTC facility.

D. IEHP DualChoice Members do not require a three (3) day acute hospital stay prior to admission to an LTC.

PURPOSE:

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

DEFINITIONS:

A. Long-Term Care (LTC) – Rehabilitative, restorative and/or ongoing skilled nursing care to patients or residents in need of assistance with activities of daily living.[1]

B. Skilled Care – Medically necessary care that can only be provided by or under the supervision of skilled or licensed medical personnel. Examples include but are not limited to physical therapy, wound care, intravenous injections, and catheter care.[2]

PROCEDURES:

Skilled Level Long-Term Care and Provider Responsibilities

[1] Centers for Medicaid and Medicare Services (CMS), "Custodial Care vs Skilled Care," March 2016. https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/infograph-CustodialCarevsSkilledCare-%5BMarch-2016%5D.pdf
[2] Ibid.

A. Primary Care Providers (PCPs) must evaluate a Member's need for skilled level LTC. A referral request must be submitted to the Member's IPA with sufficient medical information from the Member's PCP when transitioning from a/the community or usual setting. Determinations must be made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Practitioners (see Attachment, "UM Timeliness Standards – IEHP DualChoice" in Section 14).[3] See Policy 14D, "Pre-Service Referral Authorization Process."

   1. If the Member is in an acute facility, physician orders with treatment modalities may be documented in the medical record or appropriate forms and discussed with UM staff in lieu of a referral being submitted.

B. Adequate information must be available to determine the appropriate level of care including:

   1. The Member's level of function and independence prior to admission and currently;
   2. Caregiver/family support;
   3. Skilled care is required to achieve the Member's optimal health status;
   4. Around-the-clock care or observation is medically necessary;
   5. The realistic potential and timeline for the Member to regain some functional independence;
   6. Information obtained from Physical Therapy, Occupational Therapy, and Speech Therapy Departments, as necessary; and
   7. Evaluation of alternative care to determine if Member would be stable enough to achieve treatment goals, including:
      a. Home health care;
      b. Long term care (based upon the Member's benefit); see Policy 14F1, "Long Term Care – Custodial Level";
      c. Intermediate care (based upon the Member's benefit);
      d. Community Based Adult Services (based upon the Member's benefit; see Policy 12H, "Community Based Adult Services (CBAS)" or child day care;
      e. In-Home Supportive Services, see Policy 12F, "In-Home Supportive Services;"
      f. Family education and training; and
      g. Community networks and resources.

C. 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

[3] Title 42 Code of Federal Regulations (CFR) §§ 438.210, 422.568, 422.570, and 422.572

treatment plans.

D. Within 48 hours[4] of the Member's admission, the LTC facility must submit to the IPA all clinical documentation that demonstrate the medical necessity of the inpatient admission. If clinical documents are not received timely, the inpatient admission will be at risk for potential denial.

E. The treatment plan is implemented, evaluated, and revised by the LTC facility's 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 are also involved in the implementation of the treatment plan to the extent necessary.

F. Unless directed otherwise by IEHP, the LTC facility must, on a weekly basis, inform IEHP of the expected outcome of the Member's health status. This includes but is not limited to clinical updates, status of goals, and discharge planning (See Attachments, "Long Term Care (LTC) Initial Review Form" and "Long Term Care (LTC) Follow-Up Review Form" in Section 14).

G. Prior to transferring a Member to a hospital, or before a Member goes on therapeutic leave, the LTC facility must provide written information to the Member or Member's representative that specifies:[5]

1. That the Member has a right to a seven (7) day bed hold, during which the Member is permitted to return and resume residence.
2. The LTC facility's policy regarding bed holds, consistent with the following:
    a. If the Member's hospitalization or therapeutic leave exceeds the bed hold period of seven (7) days, but the Member still requires the services provided by the LTC facility and is still eligible for said services, the Member may still return to their previous room if available, otherwise they will be able to return immediately upon the first availability of a bed in a semi-private room.[6]

H. If an LTC facility determines that a Member who was transferred with an expectation of returning to the facility cannot return to the facility, the facility must follow the procedure for discharge in accordance with applicable state and federal requirements.[7]

I. The LTC facility must submit all clinical documentation in advance of, or at the time of the Member's discharge or transfer, and no later than within one (1) business day post-discharge.[8] If clinical documentation is not received timely, IEHP will issue a denial of payment to the facility due to lack of clinical documentation supporting medical necessity.

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[4] Department of Managed Health Care (DHCS) CalAIM Dual Eligible Special Needs Plans (D-SNP) Policy Guide – Chapter 2, Information Sharing Policy
[5] 42 CFR §483.15 (d)
[6] 42 CFR §483.15 (e)(1)
[7] 42 CFR §483.15 (e)(1)(ii)
[8] Ibid.

J. Contracted LTC facilities must use secure methods, including fax, telephone, and/or electronic data record exchange, to inform IEHP of any LTC admission, discharge, or transfer, for all Members.[9]

K. The facility provides the Member or their representative 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.[10,11]

1. The Notice of Medicare Non-Coverage (NOMNC) letter may be delivered earlier if the date that coverage will end is known.[12]
2. If the expected length of stay or service is two (2) days or less, the NOMNC letter must be given on admission.[13]
3. The NOMNC should not be used when it is determined that the Member's services should end based on the exhaustion of benefits (such as the one hundred (100) day long term care limit per benefit period).
4. The facility may deliver the NOMNC to the Member's representative. If the facility is unable to personally deliver the NOMNC to the Member's representative, then the facility should inform the representative of the following:[14]
   a. The Member's last day of covered services, and the date when the Member's liability is expected to begin;
   b. The Member's right to appeal;
   c. A description of how to request appeal by a Quality Improvement Organization (QIO);
   d. The deadline to request a review as well as what to do if the deadline is missed; and
   e. The name and telephone number of the Quality Improvement Organization (QIO).

   The date of the conversation with the Member's representative, whether by telephone or in writing, is the date of the receipt of the NOMNC. The facility shall confirm the contact by sending the annotated NOMNC to the Member's representative on that same date.

   When direct phone contact cannot be made, the facility shall send the NOMNC 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. [15]

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[9] Ibid.
[10] Title 42 Code of Federal Regulations (CFR) § 422.624 (b)(1)
[11] Medicare Claims Processing Manual, "Chapter 30 – Financial Liability Protections," Section 260.3.4
[12] Ibid.
[13] Ibid.
[14] Medicare Claims Processing Manual, "Chapter 30 – Financial Liability Protections," Section 260.3.8
[15] Medicare Claims Processing Manual, "Chapter 30 – Financial Liability Protections," Section 260.3.8

5. IEHP DualChoice Members have the right to request an immediate review by the Beneficiary and Family-Centered Care QIO (BFCC-QIO) when a facility decides to terminate previously approved coverage.[16,17]
6. The facility 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.[18]

IEHP, IPA & PCP Responsibilities

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

B. IPAs are responsible for forwarding to IEHP all requests for skilled level LTC upon receipt of the request and indicating whether the request for skilled level LTC is after an acute inpatient admission. These requests shall be forwarded to IEHP's Utilization Management Department via fax at (909) 912-1045.

C. Starting at admission, IEHP and IPAs must collaborate with the facility to ensure that all discharge needs of the Member are met.

D. IEHP and its IPAs provide all necessary care coordination for Members in LTC facilities, including coordination of all aspects of the admission, such as but not limited to:
1. Determining the appropriate contracted facility for the Member;
2. Arranging any necessary transportation services;
3. Arranging for physician coverage at the facility as needed;
4. Arranging for any necessary transfer of medical information; and
5. If the IPA determines the need to keep the Member in their usual setting with additional ancillary services, then the IPA may contact IEHP's Care Management Department.

E. IEHP is responsible for authorizing admissions and determining the appropriate level of care for LTC facility placement of Members with assistance from the Member's IPA Case Management (CM) department, as needed.

F. The criteria for admission of Medi-Cal Members to various levels of LTC facilities are described in the following sections of Title 22 of the California Code of Regulations:[19]
1. Skilled Nursing Facility - Section 51124
2. Subacute Level of Care - Section 51124.5
3. Pediatric Subacute Care Services - Section 51124.6

[16] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 100.2
[17] Medicare Claims Processing Manual, "Chapter 30 – Financial Liability Protections," Section 260.2
[18] Medicare Claims Processing Manual, "Chapter 30 – Financial Liability Protections," Section 260.4.4
[19] Title 22 California Code of Regulations (CCR) § 51124

4. Intermediate Care Services - Section 51120

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

1. The Member requires continuous availability of skilled nursing services or skilled rehabilitation services daily.
2. Only contracted LTCs are utilized unless none are available, then a letter of agreement (LOA) is requested prior to admission.
3. The Member's eligibility and schedule of benefits are verified prior to authorizing appropriate services and within the first five (5) days of each month.

H. Authorization details will be available for the facility to view on the secure IEHP Provider portal once facility face sheet, admission orders, MC 171 form, and if indicated, inter-facility transfer form have been received by IEHP. Non-contracted facilities are provided authorization details verbally.

I. IEHP begins performing concurrent review at admission and may perform this onsite by chart review or telephonically. Continued and subsequent reviews are performed using IEHP-approved authorization criteria. See Policy 25E1, "Utilization Management – Delegation and Monitoring."

1. Clinical progress notes must be received within two (2) business days of admission and at least weekly until discharge, unless directed otherwise by the IEHP LTC Review Nurse.
2. Timely submission of clinical progress notes is required in order to determine whether continued stay at this level of care remains medically necessary. Therefore, untimely submission of clinical progress notes could result in denial of skilled days.
3. Discharge planning should begin upon admission. IEHP must be informed of any discharge need requiring authorization as soon as need is known and prior to day of discharge (see Attachment, "Service Request Form for Skilled Nursing Facilities" in Section 14).

J. Reviews should include physician communication and ongoing communication with other healthcare professionals involved in the Member's care as necessary. The IPA must review and make the best clinical decision possible based on the clinical documentation provided by the skilled nursing facility. Authorization decisions must be made within two (2) business days of receipt of request.

K. UM 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 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. Financial responsibility for IEHP DualChoice Members continues for up to one hundred (100) days per benefit period. The IPA will ensure that the Member is admitted to a contracted facility, as applicable. The IPA is responsible for notifying the 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.

O. 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 skilled care greater than the one hundred (100) days LTC skilled limit per benefit period by faxing the LongTerm Care (LTC) Data Sheet along with the face sheet to (909) 912-1045. (See Attachment, "Long Term Care (LTC) Data Sheet" in Section 14).

P. When a QIO notifies the IPA that the Member or their authorized representative has requested an expedited review, the IPA must complete and fax to IEHP the packet of deliverables requested by the QIO. This includes a copy of the NOMNC, copy of the Detailed Explanation of Non Coverage (DENC), hospital face sheet, admission orders, history and physical, and clinical documentation to justify the discharge plan.

   1. If approved, IEHP's UM Team will forward the packet to the QIO. If revisions are required, IEHP UM Team will notify the IPA by phone with instructions on how to submit revisions back to IEHP.

Q. PCPs must conduct follow-ups with discharged Members within appropriate timeframes. IEHP provides an Inpatient Discharge roster, accessible through the IEHP Provider Portal landing page, which displays the follow-up due date for Members.

R. IEHP will authorize bed holds as follows.

   1. A separate authorization will be issued for up to a seven (7) calendar day bed hold.
   2. If the Member does not return to the LTC facility who requested the hold in seven (7) calendar days, the bed hold will expire.
   3. The LTC facility must accept the Member back, if requested, in order to receive payment for the bed hold.
   4. Bed hold is reserved for Members that intend to return to the LTC facility.

S. IEHP does not require new Members residing in out-of-area/out-of-network Skilled Nursing Facility (SNF) to relocate unless it is determined that relocation is medically necessary or if the out-of-area/out-of-network SNF does not meet the requirements of continuity of care as outlined in Policy 12A2, "Care Management Requirements - Continuity of Care."

T. IEHP will authorize Accommodation Codes as follows:

   1. Accommodation codes require an authorization within the inpatient authorization.

2. All accommodation codes are approved on a case-by-case basis after review of supporting clinical documentation.
3. Accommodation code 560 does not apply to the use of alcohol and marijuana.
4. Accommodation codes do not apply to custodial level of care, unless otherwise indicated by IEHP's Medical Director for a limited period of time.

INLAND EMPIRE HEALTH PLAN		
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14. UTILIZATION MANAGEMENT

G. Acute Inpatient and Behavioral Health Admission and Concurrent Review

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. IEHP and its IPAs have policies and procedures that establish the process by which they prospectively, retrospectively, or concurrently review and approve, partially approve (modify), or deny, based in whole or in part on medical necessity, services requested by Providers for Members. These policies and procedures ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes.[1]

B. IEHP and its IPAs ensure the provision of discharge planning when a Member is admitted to a Hospital or Long-Term Acute Care (LTAC) facility and continuation into the post-discharge period. This shall ensure that necessary care, services, and supports are in place in the community for the Member once they are discharged.

PURPOSE:

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

PROCEDURES:

BH Admission and Concurrent Review

A. IEHP maintains and manages a BH Provider Network to provide behavioral health professional services. All IEHP DualChoice Members can self-refer to IEHP to receive behavioral health professional services or be referred by a Primary Care Provider (PCP).

B. IEHP authorizes and manages all levels of behavioral health care including acute psychiatric hospitalization, partial psychiatric hospitalization, intensive outpatient services, and outpatient care.

C. Members requiring detoxification are authorized and managed according to the Division of Financial Responsibilities (DOFR).[2,3]

Hospital/Facility Responsibilities

A. Contracted and non-contracted Hospitals and LTAC facilities must notify IEHP or the

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[1] California Health and Safety Code (Health & Saf. Code) § 1367.01
[2] Memorandum of Understanding (MOU) between IEHP and Riverside University Health System-Behavioral Health (RUHS-BH), Mental Health Services, 03/12/18
[3] MOU between IEHP and San Bernardino County Department of Behavioral Health (SBDBH), Mental Health Services, 02/12/18

Member's IPA per below upon the Member's planned or unplanned inpatient admission or as soon as the facility deems the need to obtain authorization for the inpatient stay. If circumstances do not allow for more timely notification, contracted hospitals must make this notification either immediately prior to, or at the time of, the Member's discharge or transfer from the hospital's inpatient services (if applicable) at the very latest.

B. Contracted hospitals must use secure methods, including fax, telephone, and/or electronic data record exchange, to inform IEHP of any hospital admission for all Members.[4]

1. For IEHP-Direct Members, notification of acute admission may be done via fax at (909) 477-8553, phone or electronic data record exchange. Non-contracted facilities can notify IEHP of admission 24 hours a day by phone at (866) 649-6327.
2. For BH admissions, notification may be faxed to IEHP at (844) 500-0440. Non-contracted BH facilities can notify IEHP of admission 24 hours a day by phone at (866) 649-6327.
3. Hospitals do not need to supply IEHP a notification of admission for standard obstetric (OB) deliveries. No prior authorization is needed for these services and hospitals should bill post-discharge. Please refer to Section 20 "Claims Processing" for additional guidance on billing procedures. Length of stay for standard OB deliveries is defined as follows:[5]

   a. Two (2)-day stay for vaginal delivery
   b. Four (4)-day stay for cesarean delivery

   Authorization is required for admissions that exceed these standard lengths of stay. In such instances, Hospitals must provide IEHP with notification of admission and clinical documentation along with a request for authorization within one (1) business day of exceeding the standard length of stay.

C. Within one (1) business day of notification of the Member's admission, the Hospital or LTAC facility must submit to the IPA (for acute admission) or to IEHP (for BH admission) all clinical documentation that demonstrate the medical necessity of the inpatient admission. If clinical documents are not received timely, the admission will be at risk for timely review and may potentially be denied.

D. The Hospital or LTAC facility must begin discharge planning upon admission and inform the Member's IPA for acute admission or IEHP for BH admission, of any discharge needs requiring authorization as soon as need is known and no later than the day prior to day of discharge (see Attachment, "Acute Hospital Discharge Needs Request Form" in Section 14).

E. Discharge planning must ensure that necessary care, services, and supports are in place in the

[4] Department of Managed Health Care (DHCS) CalAIM Dual Eligible Special Needs Plans (D-SNP) Policy Guide – Chapter 2, Information Sharing Policy
[5] Title 45 Code of Federal Regulations (CFR) §146.130

community for the Member once they are discharged from the Acute or BH Hospital/Facility or LTAC, including scheduling an outpatient appointment and/or conducting follow-up with the Member and/or caregiver.[6] Discharge planning must include, at minimum:

1. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received;
2. Documentation of pre-discharge factors, including an understanding of the medical condition or functional status by the Member or their representative, physical and mental health status, financial resources, and social supports;
3. Services needed after discharge, type of placement preferred and agreed to by the Member or their representative, specific agency recommended by the facility and agreed to by the Member, and pre-discharge counseling recommended; and
4. Summary of the nature and outcome of the Member or their representative's involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action identified by the facility.

F. Within one (1) business day post-discharge, the Hospital or LTAC facility must submit all clinical documentation to the Member's IPA for acute admission, or to IEHP for BH admission. If clinical documentation is not received timely, the IPA or IEHP will issue a denial of payment to the facility due to lack of clinical documentation supporting medical necessity.

G. The attending Physician is responsible for the Member's care while hospitalized and must perform the following functions:

1. Assess the Member's medical status upon admission, determine level of care and estimated length of stay, and document this information in the medical record;
2. Verify that appropriate medical criteria were utilized for inpatient admission;
3. Communicate the medical assessment to IEHP or IPA UM/CM staff either verbally or in writing; and
4. Continue to document medical necessity in the medical record for the duration of the Member's Hospital stay.

H. Members have the right to request an expedited review by the Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO) of a decision that inpatient hospital care is no longer necessary.

I. Facilities, including acute, rehabilitation, LTAC and psychiatric, must notify Members who

[6] Title 42 Code of Federal Regulations (CFR) 482.43

are inpatient about their Hospital discharge appeal rights.[7]

1. Facilities must issue the Important Message from Medicare (IM) within two (2) calendar days of admission, must obtain the signature of the Member or his or her representative and provide a copy at that time to the Member/Member's representative.[8] A follow-up copy of the signed IM must be delivered to the Member:[9]
    a. A follow up copy must be delivered no more than two (2) calendar days before the planned date of discharge.
    b. When discharge cannot be predicted in advance, the follow up copy may be delivered as late as the day of discharge giving the Member at least four (4) hours to consider their right to request a QIO review.
    c. If delivery of the original IM is within two (2) calendar days of the date of discharge, no follow up notice is required.
2. 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.[10]
3. 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.[11]
4. When a QIO notifies the Hospital that the Member has requested an expedited review, the facility delivers to the Member the Detailed Notice of Discharge. This template is available online at www.iehp.org.

J. For information on the authorization of post-stabilization care, please see Policy 14C, Emergency Services.

IPA & PCP Responsibilities for Non-BH Inpatient Utilization Management

A. IPAs are responsible to perform inpatient utilization management activities as outlined in their contract. IPAs that have accountability for inpatient utilization management must notify IEHP of Members with inpatient stay on day twenty (20) and weekly by completing and faxing the Acute Inpatient Data Sheet along with the face sheet to (909) 477-8553 (See Attachment, "Acute Inpatient Data Sheet" in Section 14). Subsequent reviews must be sent to IEHP weekly until the Member is discharged.

B. The Member's IPA performs admission review within one (1) business day of knowledge of admission.

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[7] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 100.1
[8] Medicare Claims Processing Manual, "Chapter 30 – Financial Liability Protections, Section 200.3.1
[9] Medicare Claims Processing Manual, "Chapter 30 – Financial Liability Protections, Section 200.3.2
[10] Medicare Claims Processing Manual, "Chapter 30 – Financial Liability Protections, Section 200.3.1
[11] Ibid.

C. The Member's IPA performs concurrent review daily for per diem contracts or based on clinical criteria for Medicare Severity Diagnosis Related Group (MS-DRG) contracts until discharge. Concurrent review can be performed either on-site by chart review or telephonically.

D. Reviews are performed based on nationally recognized clinical criteria and IEHP Utilization Management Subcommittee Approved Authorization Guidelines. Reviews may also include physician communication and ongoing communication with other healthcare professionals involved in the Member's care, as necessary. Determinations are made within one (1) business day of receiving all clinical documentation, and are communicated to the facility within twenty-four (24) hours of the decision.[12] Please see Policy 25E1, "Utilization Management Delegation and Monitoring" for more information on authorization process requirements.

   1. A tracking number may be issued as necessary prior to the admission or transfer for services such as transfer to higher level of care, LTAC, skilled nursing facility (SNF), or acute rehabilitation (AR).

   2. Contracted facilities can view their authorizations on the secure IEHP Provider portal, while non-contracted facilities are verbally notified of their authorizations.

E. If the Member's IPA denies the continued stay and the attending physician does not agree with the decision, either the attending physician or the Member may initiate an expedited appeal. Following completion of the expedited review process, the admission is either authorized or denied. Care must not be discontinued until the treating Practitioner has been notified and the treating Practitioner has agreed upon a care plan.[13] Please see Section 16, "Grievance and Appeal Resolution System" for more information.

F. For denials of care or service, the Member's IPA must notify the Hospital/Facility within twenty-four (24) hours of the receipt of request - i.e., receipt of clinical documentation. If oral notification is given within twenty-four (24) hours of the request, then a written or electronic notification is given no later than three (3) calendar days after the oral notification. If the denial is either concurrent or post-service (retrospective) and the Member is not at financial risk, the Member does not need to be notified.[14]

G. IPAs must have post-transition discharge policies and procedures that ensure, in collaboration with IEHP, access to medical care and follow-up, medications, durable medical equipment (DME) and supplies, transportation, and integration of community-based Long-Term Services and Supports (LTSS) programs. Please see Policies 12A2, "Care Management Requirements – Individual Care Plan" and 25C1, "Care Management – Delegation and Monitoring" for more information on care coordination and care management responsibilities that are delegated to

[12] CA Health & Saf. Code § 1367.01
[13] Ibid.
[14] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 40.12.1

IPAs.

H. When a QIO notifies the IPA that the Member or their authorized representative has requested an expedited review, the IPA must complete and fax to IEHP the packet of deliverables requested by the QIO. This includes a copy of the Important Message, copy of the Detailed Notice of Discharge, hospital face sheet, admission orders, history and physical, and clinical documentation to justify the discharge plan.

   1. If approved, IEHP's UM Team will forward the packet to the QIO. If revisions are required, IEHP UM Team will notify the IPA by phone with instructions on how to submit revisions back to IEHP.

I. PCPs must conduct follow-ups with discharged Members within appropriate timeframes. IEHP provides an Inpatient Discharge roster, accessible through the IEHP Provider Portal landing page, which displays the follow-up due date for Members.

J. Chronic, complex, high risk, high cost, re-admissions or catastrophic cases are referred for potential care management, transition of care and/or disease management interventions.

Monitoring and Oversight

A. IEHP and its IPAs must ensure that Provider-Preventable Conditions (PPCs) are reported to the California Department of Health Care Services (DHCS).[15,16,] Please see Policy 13D, "Reporting Requirements Related to Provider Preventable Conditions" for more information.

INLAND EMPIRE HEALTH PLAN		
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Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

[15] Title 42, Code of Federal Regulations (CFR) § 438.3
[16] Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 17-002 Supersedes DPL 15-002, "Reporting Requirements Related to Provider Preventable Conditions

14. UTILIZATION MANAGEMENT

H. Hospice Services

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. Members that elect to receive the Medicare hospice benefit, remain enrolled in IEHP DualChoice and obtains the hospice care through their Medicare Fee-For-Service benefit.[1]

PROCEDURE:

A. Members, who elect hospice care but choose not to disenroll from IEHP DualChoice, are entitled to continue to receive Medicare benefits through the health plan, other than those benefits that are the responsibility of the hospice care Provider.

B. Evaluation by a Medicare-certified hospice provider does not require prior authorization from IEHP

C. IPAs must provide ongoing care coordination to ensure that services necessary to diagnose, treat, and follow up on conditions not related to the terminal illness, continue to be provided and initiated as necessary.

INLAND EMPIRE HEALTH PLAN			
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Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

[1] Medicare Managed Care Manual, "Chapter 4 – Benefits and Beneficiary Protections," Section 10.2.2

14. UTILIZATION MANAGEMENT

I. Expedited Initial Organization Determinations

APPLIES TO:

A. This policy applies to all IEHP DualChoice Members.

POLICY:

A. IEHP and its IPAs perform Expedited Initial Organization Determinations (EIOD) for service authorization requests where the Provider indicates or IEHP or the IPA determines that following the standard timeframe could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.[1]

PROCEDURES:

A. The Member, Member's representative or treating Provider may submit an oral or written request for an EIOD. EIODs may not be requested for cases in which the only issue involves claims payment for services the Member has already received.[2]

B. An EIOD is automatically provided when the request is made or supported by a Provider. The Provider 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.[3]

C. If it is determined that the Member's condition does not warrant an expedited determination, the IPA must verbally notify the Member 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.[4]

   1. The written notification is made through the Expedited Criteria Not Met template, which:[5][MW1][AH2]

      a. Explains that the request will be processed using the fourteen (14) calendar day timeframe for standard determinations;

      b. Informs the Member of their right to file an expedited grievance if he or she disagrees with the decision to not expedite the determination;

      c. Provides instructions for filing an expedited grievance and its timeframes;

      d. Informs the Member of the criteria for expedited reviews and of their right to resubmit a request for an EIOD with their Provider's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life

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[1] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.8.a
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.12.1

or health of the Member or the Member's ability to regain maximum function; in which case, the request will be expedited automatically.

This and other notification templates are available online at www.iehp.org.

2. The request will automatically be processed for a determination within the standard timeframe of fourteen (14) calendar days from the day the request was received for an EIOD.[6]

D. If the request is accepted for an EIOD, the determination must be made in accordance with the following requirements:[7]

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

2. If the initial verbal notification to the Member of the expedited determination was successful, then written notification to the Member must occur within three (3) calendar days of the verbal notification. All attempts of verbal communication with Members must be documented with the time, date, and initials of IEHP or IPA staff making the call; and

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

E. 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. See Policy 25E1, "Utilization Management – Delegation Monitoring" for denial notice requirements. An extension of no more than fourteen (14) calendar days may be allowed to perform the review under the certain circumstances (See Attachment, "UM Timeliness Standards – IEHP DualChoice" in Section 14). Extensions must not be used to pend organization determinations while waiting for medical records from contracted Providers.[8]

F. If clinical information is needed from a non-contracted provider, IEHP or the IPA will request this information within twenty-four (24) hours of the initial request for an EIOD. Non-contracted provider must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist in meeting the required timeframe. Regardless of whether IEHP or the IPA requests clinical information from non-contracted providers, IEHP and its IPAs are still responsible for meeting the same timeframe and notification requirements for EIODs.

G. IEHP or the IPA must notify the Member in writing of the reason for the delay, utilizing the Extension Needed for Additional Information template, and inform them of their right to file

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[6] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.12.1
[7] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.8
[8] Ibid.

an expedited grievance if the Member disagrees with the decision for an extension.[9] The written notification for the extension will include the clinical information needed or the test or examination required. This and other notification templates are available online at www.iehp.org.

H. Timeframe and notification requirements for all EIOD requests are identified and reviewed through the Referral and Denials and Partial Approval universes submitted by the IPAs on a monthly basis. See Policy 25E2, "Utilization Management - Reporting Requirements."

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2007
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

[9] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.8

14. UTILIZATION MANAGEMENT

Attachments

DESCRIPTION	POLICY CROSS REFERENCE
Acute Inpatient Data Sheet	14G
Acute Hospital Discharge Need Request Form	14G
Health Plan Referral Form for Out-of-Network and Special Services	25E1
Long Term Care (LTC) Data Sheet	14F2
Long Term Care (LTC) Follow-up Review Form	14F2
Long Term Care (LTC) Initial Review Form	14F2
Medicare Non-Covered Services	25E1
PCP Referral Tracking Log	14A1, 14B
Service Request for Skilled Nursing Facilities	14F2
Specialty Office Service Auth Sets Grid	14D
Standing Referral / Extended Access Referral to Specialty Care	14A3
UM Timeliness Standards – IEHP DualChoice	14D, 14E, 25E1
Referral Audit CAP Notification Letter	14A1
Referral Audit Corrective Action Plan Tool	14A1

ACUTE HOSPITAL DISCHARGE NEEDS REQUEST

REQUEST INFORMATION

Request Date: ____________ **Requested By:** ____________

Requesting Hospital: ____________

Member Name: ____________

IEHP Member ID: ____________ **Expected Discharge:** ____________

ICD/Diagnosis Code: ____________

REQUESTED SERVICES

☐ HLOC — LOC/Service: ____________

☐ LTAC — LOC/Service: ____________

☐ Acute Rehab — ☐ PT ☐ OT ☐ ST ☐ IV: ____________

☐ Post-Acute Skilled — ☐ PT ☐ OT ☐ ST ☐ IV: ____________

☐ Post-Acute Custodial — LOC: ____________

☐ Home Health — ☐ SN ☐ PT ☐ OT ☐ ST Other/Freq: ____________

☐ DME — HCPCS: ____________

☐ **ORDERS ATTACHED:** Physician orders & clinical documentation are **required** for all services listed above.

*LOC, Services and/or HCPCS **must** be completed for each service category requested.*

REQUESTED PROVIDER INFORMATION

Accepting Provider Name: ____________

Provider Address: ____________

Phone: ____________ **Fax:** ____________

Contact Person: ____________ **Confirmed?** ☐ Yes ☐ No

NOTES

Please submit requests directly to the facility assigned IEHP Inpatient Nurse Case Manager.

Acute Inpatient Data Sheet

(20 Day Stays and Greater)

IPA Name ______________________ **Date Submitted** ______________________

Submitted By ______________________ **Contact Number** ______________________

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

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

<u>*Legend:</u>

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

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

This form is for services requiring health plan review.

1. Referrals

DATE: ______________________ ❑ **EXPEDITED** - Decision w/in 72 hours ❑ **ROUTINE** ❑ **PATIENT REQUESTED** ❑ **RETRO** ❑ **CPO Services** ❑ **CBAS**	(TO BE COMPLETED BY IEHP) **AUTH/TRACKING NUMBER:** ______________________ **AUTH/EXPIRATION DATE:** ______________________

2. GENERAL INFORMATION

Member Name (please print)	DOB	ID #	
Plan *(select one)* ❑ Medi-Cal	❑ Non-State Programs	❑ Open Access	❑ Medicare
Address	City	Zip	Phone
Diagnosis (Required)		**Diagnosis Code (REQUIRED)**	

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

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

3. SERVICE REQUESTED

Service Requested *(check one)*	❑ 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) 890-5751

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

IPA Name: ______________________ Date Submitted: ______________________

Report for Month of: ________________ Submitted by: ______________________

Member Name	Member ID	Facility Name	Attending Physician	Reason for Admit (deconditioning, IVABX, wd care, etc.)	Admission/ Enrollment Date	Last Cover Date (LCD)	Total SNF Days (Include past & present days)	Prior Residence *See Legend:	Is Member at risk for custodial care? Why?	Member Remains Skilled or Custodial

***Legend:**

BC = Board & Care
GH = Group Home
LA = Lives Alone
AL = Assisted Living
HL = Homeless
SNF = Skilled Nursing Facility

LTC FOLLOW-UP REVIEW

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

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

Facility:

Name *(Last, First, M.I.):* **DOB:** **Reference #** **ID #**

Activity Level: **Height:** **Weight:**

DCP: ☐ LTC ☐ B&C ☐ Home ☐ Home with HH ☐ Home with CBAS ☐ Home with IHSS/hr/mo | #hrs/month:

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: ☐ O_2 ☐ Cane ☐ Gurney ☐ Wheelchair

CONTINUED CARE NEEDS

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

☐ Chemo	☐ Eloper/ Wanderer	☐ Ileostomy	☐ O_2	☐ Trach	**Wounds**	☐ Surgical	☐ Pressure
☐ Colostomy	☐ Foley Cath	☐ Isolation	☐ Smoker	☐ Other:		☐ Arterial	#:
☐ Coma	☐ G/J Tube	☐ NG Tube	☐ Radiation	☐ Suctioning/ Frequency:		☐ Venous	Stage(s):
☐ Dialysis	☐ HHN	☐ NPO	☐ TPN			☐ Foot Wounds	

Activity Level	Bed Mobility	☐ Max	☐ Mod	☐ Min	☐ Assist	☐ Independent
	Supine to Sit	☐ Max	☐ Mod	☐ Min	☐ Assist	☐ Independent
	Sit to Supine	☐ Max	☐ Mod	☐ Min	☐ Assist	☐ Independent

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

• Gait Distance	x	ft.				
• Wheelchair Mobility	x	ft.	☐ Min	☐ Mod	☐ Max Assist	☐ Independent
• Safety/Balance	☐ Good	☐ Fair	☐ Poor			
• Endurance	☐ Good	☐ Fair	☐ Poor			
• Dressing Upper Body	☐ Min	☐ Mod	☐ Max Assist	☐ Independent		
• Dressing Lower Body	☐ Min	☐ Mod	☐ Max Assist	☐ Independent		
• Toileting	☐ Min	☐ Mod	☐ Max Assist	☐ Independent		
• Bathing	☐ Min	☐ Mod	☐ Max Assist	☐ Independent		
• Personal Hygiene	☐ Min	☐ Mod	☐ Max Assist	☐ Independent		

Treatment Goals Set:

Treatment Goals Met:

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

Updates to Discharge Plan:

Date of Review　　Nurse Reviewer Printed Name　　Nurse Reviewer Signature　　Contact Phone Number

SNF INITIAL REVIEW

Please fax completed form to your facility's assigned IEHP Nurse.
All questions contained in this questionnaire are strictly **confidential** and will become part of the Member's medical record.

Name *(Last, First, M.I.)*: **DOB:** **Auth #** **Admission Date:**

Facility: **Attending:**

Admit Dx: **Height:** **Weight:**

Co-Morbidities:

Admit Level of Care: ☐ Sub acute ☐ Level 4 ☐ Level 3 ☐ Level 2 ☐ Level 1 ☐ Custodial

Justification for Level:

DCP: ☐ LTC ☐ B&C ☐ Home ☐ Home with HH ☐ Home with CBAS ☐ Home with IHSS/hr/mo #hrs/month:

Current Barriers to DCP:

Treatment Goals:

Prior Living Conditions:

Prior Level of Function:

Does Member have social or family support? ☐ Yes ☐ No **Describe:**

Does Member own DME? ☐ Yes ☐ No **Type?**

Does Member have income? ☐ Yes ☐ No **How much per month?**

Does Member Have an Advance Directive or Living Will? ☐ Yes ☐ No **DPOA:** **Phone Number:**

Does SNF Facility Provide Transportation? ☐ Yes ☐ No ☐ Other:

Indicate Transportation Needs: ☐ O_2 ☐ Cane ☐ Gurney ☐ Wheelchair

Does Member have the potential to go back home when ready for discharge? ☐ Yes ☐ No **If No, Why?**

PATIENT SUPPORT/CAREGIVER

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

PERSONAL SAFETY & ACTIVITY LEVEL

Resident Care Needs *(Check all conditions that apply)*:
Dietary Requirements/Restrictions:

					Wounds		
☐ Chemo	☐ Eloper/ Wanderer	☐ Ileostomy	☐ O_2	☐ Trach		☐ Surgical	☐ Pressure
☐ Colostomy	☐ Foley Cath	☐ Isolation	☐ Smoker	☐ Other:		☐ Arterial	#:
☐ Coma	☐ G/J Tube	☐ NG Tube	☐ Radiation	☐ Suctioning/ Frequency:		☐ Venous	Stage(s):
☐ Dialysis/Days	☐ HHN	☐ NPO	☐ TPN			☐ Foot Wounds	

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

Current Level of Functioning:

Discharge Plan:

ADMISSION PACKET CHECKLIST (PLEASE SEND WITH ALL NEW)

Facesheet	☐ Yes	☐ No	**H & P**	☐ Yes	☐ No
Physician Orders	☐ Yes	☐ No	**Wound Notes** (If applicable)	☐ Yes	☐ No
IFT (Inter-facility transfer form)	☐ Yes	☐ No	**SNF Initial**	☐ Yes	☐ No
MC171	☐ Yes	☐ No	**Therapy Evaluation** (Skilled)	☐ Yes	☐ No
MDS (Custodial)	☐ Yes	☐ No	**Assigned SNFIST**	☐ Yes	☐ No

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

Name the Drug(s):	**Strength:**	**Frequency Taken:**

Date of Review ______ Nurse Reviewer Printed Name ______ Nurse Reviewer Signature ______ Contact Phone Number ______

This chart alphabetically lists the services/items that must be forwarded to the Plan for review and determination because they are services/items that Medicare does not cover. **Codes not listed in this list or in the Division of Financial Responsibility (DOFR) require to be reviewed by the IPA.**

CPT Code	Description	Comments
E0240, E0241, E0243, E0244, E0245, E0246, E0247, E0248	Bathroom Equipment (shower chair, transfer bench, grab bars)	
E0603	Breast Pump (electric)	
A6530-A6549	Compression Stockings	
92590, 92591, 92594, 92595, V5010, X4542	Hearing aid exams	
V5298, V5264, V5265, V5014, V5120-V5264	Hearing Aids/Molds/Repair/Accessories/ Services	
T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, T4536, T4537, T4540, T4541, T4542, T4543, T4544, A6250, A4335, A4927	Incontinence Supplies (diapers, Chux, pull-ons, liners, pads, cream, wash, gloves)	Typically described by "T" HCPC code
E0118	Knee Scooter	
K0800, K0801, K0802, K0806, K0807, K0808, K0812, K0813, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886, K0890, K0891, K0898	Powered Wheelchair/Powered Operated Vehicle **that do not meet Medicare criteria**	IPA is responsible for ensuring a physiatry evaluation from an independent evaluator has been done and is attached before forwarding to IEHP
E0445, A4606	Pulse Oximeter	
E1399	Stairway Chair Lift/Stair Lift	

PCP Referral Tracking Log

Date of Service	Date Referral Sent to IPA & Name of IPA	Member Name & Date of Birth	Acuity of Referral (Urgent or Routine)	Reason for Referral/Dx	Service or Activity Requested	Date Auth. Received	Referral Decision** (Approved or Denied/Partially Approved (Modified))	Date Patient Notified	Date Appt or Service	Date of Consult Report Received	Outreach Documentations
			❑ Routine ❑ Urgent				❑ Approved ❑ Denied or Partially Approved (Modified)				1st 2nd 3rd
			❑ Routine ❑ Urgent				❑ Approved ❑ Denied or Partially Approved (Modified)				1st 2nd 3rd
			❑ Routine ❑ Urgent				❑ Approved ❑ Denied or Partially Approved (Modified)				1st 2nd 3rd
			❑ Routine ❑ Urgent				❑ Approved ❑ Denied or Partially Approved (Modified)				1st 2nd 3rd
			❑ Routine ❑ Urgent				❑ Approved ❑ Denied or Partially Approved (Modified)				1st 2nd 3rd
			❑ Routine ❑ Urgent				❑ Approved ❑ Denied or Partially Approved (Modified)				1st 2nd 3rd
			❑ Routine ❑ Urgent				❑ Approved ❑ Denied or Partially Approved (Modified)				1st 2nd 3rd

SAMPLE

Referral Audit Corrective Action Plan

Referral tracking process

Health Plan verification and date	CRITERIA	Deficiency Cited/Reviewer Comments	Corrective Action	CORRECTION DATE AND /OR PRACTITIONERS COMMENTS.	Responsible MD or Designee at Site
	RT 1 ☐	All referrals are not being tracked from the date the patient is seen in the office to when the referral is completed and submitted to the IPA/Medical Group.	All referrals are to be completed and submitted to the IPA/Medical Group within two (2) working days or less. • **Copy of the completed referral log/ or tracking process is attached.**		
	RT 2 ☐	All referrals do not include ICD-10 codes	Copy of three (3) completed referrals including the ICD-10 codes will serve as evidence the new process has been implemented. • **Copies of referrals attached.**		
	RT 3 ☐	All referrals do not include CPT codes	Copy of three (3) completed referrals including the CPT codes will service as evidence the new process has been implemented. • **Copies of referrals attached.**		

	RT 4 ☐	All referrals do not include the physician/provider signature or identifier.	Copy of three (3) completed referrals including the physician/provider signature or identifier as evidence the new process has been implemented • **Copies of referrals attached.**		
	RT 5 ☐	The office is not tracking when referrals are returned from the IPA/Medical Group with referral decisions.	All referral decisions will be made within five (5) working days or less. • **Copy of the completed referral log/ or tracking process is attached**.		
	RT 6 ☐	There is no tracking system noted or documentation when consult reports are received or attempts to obtain outside reports.	Documentation (date) when consult reports are received or attempts to obtain outside reports. Consult reports are received within ninety (90) days of the patient's appointment. OR Attempts to obtain reports will occur within thirty (30) days of the date of the referral. • **Copy of the completed referral log/ or tracking process is attached.**		

CAP COMPLETION SIGNATURE PAGE.

I have completed the corrective action plan for the Referral Audit performed on ______________________. I affirm each
(Enter Date of Review)

Corrective action has been implemented as indicated on the attached Corrective Action Plan.

____________________________	____________________________	______________
Physician/Designee Signature	**Printed Name and Title**	**Date**

Please Return Completed CAP
And this signature sheet. via U.S. Mail or FAX to:

Inland Empire Health Plan
Quality Management Department
Attention: QM Coordinator
P.O. Box 1800, Rancho Cucamonga, CA 91729-1800
Fax: (909) 890-5746

Referral Audit 1st CAP Notification Letter

Date of Review:

Health Plan Performing Evaluation:					
Reviewer's Name/Title (Print):		**Reviewer's signature/Title:**			
Facility Name:	PCP Name(s):			# of Referrals Reviewed:	
Address:		Contact Person and Title:			
Telephone:	Fax:				
Referral Audit Score:	**Date CAP Due:**		**Date of Re-assessment:**		

Corrective Action Plan (CAP) Completion and Submission Requirements

Disclosure and Release

I have received and reviewed copies of the above listed evaluation and corrective action plans for the referral audit. I agree to correct each identified deficiency by implementing any corrective action that may be required. **I understand that failure to correct any of the noted deficiencies within the required 30 calendar day time period from the review date,** may result in the exclusion of this facility and the associated provider(s) from the roster. **The completed CAP must include evidence of correction** {e.g. a tracking log or process used to track referrals} **and dates completed**.

For assistance in completing the CAP, please call _______________RN at ________________.

______________________________	______________________________	______________
Physician/Designee Signature	**Printed Name and Title**	**Date**

Please Return Completed CAP via U.S. Mail or FAX to:

Inland Empire Health Plan
Quality Management Department
P.O. Box 1800, Rancho Cucamonga, CA 91729-1800
Fax: (909) 890-5746 Attention: QM Coordinator

INLAND EMPIRE HEALTH PLAN

SERVICE REQUEST FORM FOR SKILLED NURSING FACILITIES

REQUEST URGENCY (PLEASE SELECT ONE)

☐ Standard Request

☐ Expedited Request (requires justification documented below or will revert to Standard)

- ☐ Member's life is in serious jeopardy
- ☐ Member's health is in serious jeopardy
- ☐ Member's ability to regain maximum function is in serious jeopardy
- ☐ Member discharging within 24 hours

REQUEST INFORMATION

Request Date: ______________ **Requested By:** ______________

Requesting Provider: ______________

Phone: ______________ **Fax:** ______________

Member Name: ______________ **DOB:** ______________

IEHP Member ID: **Expected Discharge:**

REQUESTED SERVICES

PLEASE SUBMIT ONLY ONE (1) SERVICE REQUEST PER FORM

Requested Service: ______________

CPT/Procedure Code(s): Please contact Provider office to obtain correct procedure codes

CPT #1: ______________ **CPT #4:** ______________

CPT #2: ______________ **CPT #5:** ______________

CPT #3: ______________ **CPT #6:** ______________

ICD/Diagnosis Code(s): Please provide diagnosis codes pertaining to this request

ICD #1: **ICD #2:**

SERVICING PROVIDER INFORMATION

Provider Name: ______________ **NPI:** ______________

Provider Address: ______________

Phone: ______________ **Fax:** ______________

Contact Person: **Confirmed?** ☐ Yes ☐ No

***** FORM REQUIREMENTS *****

Complete Service Request Form in its entirety.

Attach clinical notes, signed MD orders, and supporting documents.

Fax Service Request Form and supporting all documents to (909) 912-1045.

Please Note: request will be delayed if any required information is missing.

SPECIALTY OFFICE SERVICE AUTHORIZATION SETS

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

Procedure	CPT Code
Allergy - Skin Testing for 80 or Fewer Tests	95004 up to 65
CARD – EKG (Adult & Peds)	93000
CARD – Routine Stress Treadmill (Adult)	93015
CARD – Holter Monitor (Adult & Peds)	93235
CARD – Echocardiogram (Peds only)	93303 or 93307 + 93320 + 93325
DERM – Punch Biopsy	11100
DERM – Cryotherapy of Lesions	17000, 17003, 17110
DERM – Excision of Nail & Nail Matrix	11750
NEURO - EEG Standard	95816 or 95819
ENDO – Urinalysis	81003 or 82948
ENDO – Glucose/Blood	82947
ENDO – Fine Needle Aspiration of Thyroid	10021-10022
ENT – Tympanogram	92567
ENT – Pure Tone Audiogram	92557, 92582
ENT – Cerumen Removal	69210
ENT – Nasal Cauterization Treatment of Epistaxis (Anterior or Posterior)	30901,30905
ENT – Nasal Endoscopy	31231, 31238
ENT – Removal of Foreign Body Ear or Nose	69200, 30300
ENT – Streptococcus A Screen	87880
Gastroenterology – Flex Sigmoidoscopy	45330
GYN – Urine Pregnancy Test	81025
GYN – Depo-Provera	X6051
GYN – Abnormal Pap Follow-Ups *and:*	99213-99215 (X 3)

Procedure	**CPT Code**
Colposcopy with Biopsy	57452 or 57454-455, 57460
Endometrial Biopsy	58100, 58558
LEEP	57460
Hematology - Bone Marrow Bx and/or Aspiration	38220, 38221
Hematology – Blood Smears	85007-85008
Nephrology – Urinalysis	81000-81003
Orthopedics – Total Fracture Care (Watch for CCS) X 6 mos.	By site of injury By date of service
Orthopedics – X-Rays, in office simple extremity	73000-73140
Orthopedics – Casting, Splints	
Orthopedics – DME (boot, shoe, crutches)	
Orthopedics – Joint aspiration	20600-20615
Orthopedics – Trigger point injections	
Injection of Tendon & Ligament	20550-20553
Injection of Bursa	20600, 20605, 20610
Podiatry – Matrixectomy	11750
Podiatry – Debridement of Nails	11720-11721
Pulmonary – Spirometry	94010, 94060
Pulmonary – Blood Gases	82800-82810
Radiology - Mammogram	77067
- Breast Ultrasound @ radiologist suggestion	76645
- Cone View	77067
Rheumatology – T.P Injection	20552
Rheumatology – Injection of Tendon & Ligament	20550-20553
Rheumatology – Joint Aspiration	20600-20615
Surgery – Breast Biopsy	77031
Surgery – I & D of Cutaneous Abscess	10060-10061
Urology – Urinalysis	81000-81003
Urology - Cystoscopy	52000

Standing Referral and Extended Access Referral to Specialty Care

Date of Request						
IPA or Medical Group				**Phone No.**		
Primary Care Provider's (PCP) Name						
Phone No.			**Fax No.**			
Requesting Provider's Name						
Phone No.			**Fax No.**			
Other Insurance						
Member Name				**Member ID**		
Phone No.		**DOB**		**Gender**	❑ M ❑ F	
Address						
City		**State**		**Zip Code**		
Referred to (Physician Name)				**Specialty**		
Phone Number			**Fax No.**			
Primary Diagnosis				**ICD-10 Code**		
Secondary Diagnosis				**ICD-10 Code**		
When was the diagnosis first made?						
How many times has the patient been seen by the Specialist in the past year?						

PRACTITIONER TREATMENT PLAN (Please attach or complete this table.)			
# of Visits per 3 Months	**# of Visits per 6 Months**	**# of Visits per 9 Months**	**# of Visits per 12 Months**

Briefly describe what is anticipated from each visit:

IMPORTANT
• Additional information regarding the treatment plan may be requested from the Specialist, if necessary. If so, decision will be made within three (3) business days of receipt of the information. • Authorization remains valid only if the Member is eligible. • Payment is contingent upon the Member's eligibility at the time the service was rendered.

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

Type of Request	Decision	Notification Timeframes
Standard Initial Organization Determination (Pre-Service)	Determinations must be made five (5) business days from the Plan or Delegate's receipt of information reasonably necessary to make the determination, and no later than of 14 calendar days from when the request was received. **The Plan or Delegate may not extend the deadlines for integrated organization determinations.**	**Provider:** The written notification must be sent to the Provider within 24 hours of the decision, not to exceed 14 calendar days after receipt of the request. **Member:** The written notification must be sent to the Member within two (2) business days of the decision, not to exceed 14 calendar days after the receipt of the request.
Expedited Initial Organization Determination **-** If Expedited Criteria are not met	Promptly decide whether to expedite – determine if: 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. If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. ▪ The fourteen (14) day period begins with the day the request was received for an expedited determination.	If request is not deemed to be expedited, give the member prompt (within seventy-two (72) hours) oral notice of the denial of expedited status including the member's rights followed by written notice within three (3) calendar days of the oral notice. ▪ Use the MA Expedited Criteria Not Met template to provide written notice. The written notice must include: 1) Explain that the Health Plan will automatically transfer and process the request using the five(5)- business day timeframe for standard determinations; 2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination. 3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically; and 4) Provide instructions about the expedited grievance process and its timeframes.

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

Type of Request	Decision	Notification Timeframes
Expedited Initial Organization Determination (Pre-Service)	Determinations must be made as expeditiously as the Member's health condition requires, no later than 72 hours from when the Plan or Delegate received the request (includes weekends & holidays). **The Plan or Delegate may not extend the deadlines for integrated organization determinations.**	**Provider:** The written notification must be sent to the Provider within 24 hours of the decision, not to exceed 72 hours from when the request was received. **Member:** The written notification must be sent to the Member no later than 72 from when the request was received. ▪ **Approvals** – Oral or written notice must be given to member and provider within seventy-two (72) hours of receipt of request. – Document date and time oral notice is given. – If written notice **only** is given, it must be **received** by member and provider within seventy-two (72) hours of receipt of request. ▪ **Denials** – When oral notice is given, it must occur within seventy-two (72) hours of receipt of request and must be followed by written notice within three (3) calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be **received** by member and provider within seventy-two (72) hours of receipt of request. Use Coverage Decision Letter – 30 Day Appeal template for written notification of a denial decision.

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

Type of Request	Decision	Notification Timeframes
Standard Initial Determination for Part B Drugs	Determinations must be made as expeditiously as the Member's health condition requires, no later than 72 hours from when the Plan or Delegate received the request(including weekends and holidays).. **The Plan or Delegate may not extend the deadlines for integrated organization determinations.**	**Provider:** The written notification must be sent to the Provider within 24 hours of the decision, not to exceed 72 hours from when the request was received. **Member:** The written notification must be sent to the Member no later than 72 hours from when the request was received. Favorable, Partially Favorable or Adverse Decision: – Provide written notification to the Member and Provider of the decision as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours (including weekends and holidays) after receipt of a Standard request. – If the plan initially provides verbal notification of its decision, it must deliver written confirmation of its decision within three (3) calendar days of the verbal notification. – Use Coverage Decision Letter Part B – 7 Day Appeal template for written notification of a denial decision.

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

Type of Request	Decision	Notification Timeframes
Expedited Initial Determination for Part B Drugs	Determinations must be made as expeditiously as the Member's health condition requires, no later than 24 hours from when the Plan or Delegate received the request (including weekends and holidays). **The Plan or Delegate may not extend the deadlines for integrated organizational decisions.**	**Provider:** The written notification must be sent to the Provider within 24 hours of the decision, not to exceed 24 hours from when the request was received. **Member:** The written notification to the Member must be sent no later than 24 hours from when the request was received. Favorable, Partially Favorable or Adverse Decision: – Provide written notification to the Member and Provider of the decision as expeditiously as the Member's health condition requires, but no later than twenty-four (24) hours (including weekends and holidays) after receipt of an Expedited request. – If the plan initially provides verbal notification of its decision, it may deliver written confirmation of its decision within three (3) calendar days of the verbal notification. – Use Coverage Decision Letter Part B – 7 Day Appeal template for written notification of a denial decision.

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

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
Hospital Discharge Appeal Notices **(Concurrent)**	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 are responsible for valid delivery of the revised Important Message from Medicare (IM): 1) within two (2) calendar days of admission to a hospital inpatient setting. 2) not more than two (2) calendar days prior to discharge from a hospital inpatient setting. 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).	Hospitals must issue the IM within two (2) calendar days of admission, obtain the signature of the Member or their authorized representative and provide a copy of the IM at that time. Hospitals must issue a follow up IM not more than two (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 two (2) calendar days of discharge. ▪ When Member is being transferred from inpatient to inpatient hospital setting. ▪ For exhaustion of Part A days, when applicable. 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.	Upon notification by the QIO that a Member or their authorized 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 coverage rule or policy to the member's case. ▪ Any other information required by CMS.

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

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
Termination of Provider Services: ▪ **Skilled Nursing Facility (SNF)** ▪ **Home Health Agency (HHA)** ▪ **Comprehensive Outpatient Rehabilitation Facility (CORF)** NOTE: This process does not apply to SNF Exhaustion of Benefits (100 day limit).	The Health Plan or delegate is responsible for making the decision to end services no later than two (2) calendar days or two (2) visits before coverage ends: ▪ Discharge from SNF, HHA or CORF services **OR** ▪ A determination that such services are no longer medically necessary	The SNF, HHA or CORF is responsible for delivery of the NOMNC to the Member or their authorized representative. ▪ The NOMNC must be delivered no later than two (2) calendar days or two (2) visits prior to the proposed termination of services and must include: Member name, delivery date, date that coverage of services ends, and QIO contact information. ▪ The NOMNC may be delivered earlier if the date that coverage will end is known. ▪ If expected length of stay or service is two (2) days or less, give notice on admission. **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.	Upon notification by the Quality Improvement Organization (QIO) that a Member or authorized representative has requested an appeal: 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.