14. UTILIZATION MANAGEMENT

A. Review Procedures

1. Primary Care Provider Referrals

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal 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.[1]

B. IEHP and its Delegates must have a referral system to track and monitor referrals requiring prior authorization for the program of Utilization Management program oversight.[2] 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 ~~five~~ two (~~5~~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

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 8, Services for All Members
[2] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management Program

determination and notification of Members and Providers.[3] 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.[4]

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 report, 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);

[3] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
[4] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 13, Medical Records

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));[5]
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."

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 12K1, "Behavioral Health - Behavioral Health Services" and 12K2, "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. Please see Policy 6A, "Facility Site Review and Medical Record Review Survey Requirements and Monitoring" for more information.
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/or 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		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

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

14. UTILIZATION MANAGEMENT

A. Review Procedures

2. Standing Referral/ Extended Access to Specialty Care

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal 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 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 or specialty care center for a Member who has a life threatening, degenerative or disabling condition that requires coordination of care by a Specialist.[1,2]

B. PCPs are responsible for supervising, coordinating and providing initial and primary care to Members; for initiating referrals; and for maintaining continuity of care.[3]

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 on IEHP's Provider network by:

1. Contacting IEHP Member Services Department at (800) 440-4347 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;

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 6, Standing Referrals
[2] California Health and Safety Code (Health & Saf. Code) § 1374.16
[3] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 1, Definitions

4. Chronic obstructive pulmonary disease;
5. Chronic wound care;
6. Rehab for major trauma;
7. Neurological conditions such as multiple sclerosis and uncontrollable seizures among others; and
8. Gastrointestinal (GI) conditions such as severe peptic ulcer, 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/Extended Access Referral to Specialty Care" in Section 14).
2. Within three (3) business days of receiving this request, IEHP or the IPA must:[4,5]
   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

[4] CA Health & Saf. Code § 1374.16(c)
[5] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 6, Standing Referrals

turnaround timeframes for determination and notification of Members and Providers. ~~Please~~ See Policy 25E1, "Utilization Management – Delegation and Monitoring." ~~for more information.~~

3. The PCP must direct the Member to the Specialist within four (4) business days of the approval or partial approval (modification).[6,7]

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.[8] 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.[9]

Out of Network

A. IEHP and its IPAs are not required to refer Members to out-of-network providers unless the appropriate specialty care is not available within the network.[10,11]

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.[12]

~~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.[13]

C.

[6] CA Health & Saf. Code § 1374.16(c)
[7] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 6, Standing Referrals
[8] Title 28, California Code of Regulations § 1300.74.16(f)
[9] Ibid.
[10] CA Health & Saf. Code § 1374.16(d)
[11] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 6, Standing Referrals
[12] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 16, Out-of-Network Providers
[13] 28 CCR § 1300.74.16(g)

14. UTILIZATION MANAGEMENT

A. Review Procedures

2. Standing Referral/ Extended Access to Specialty Care

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 1999
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, ~~2022~~2023

14. UTILIZATION MANAGEMENT

A. Review Procedures
3. Other Health Coverage

APPLIES TO:

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

POLICY:

A. State law requires Medi-Cal to be the payer of last resort for services when there is a responsible third party.[1] Members with other health coverage (OHC) must utilize their OHC for covered services prior to accessing their IEHP benefits.[2]

B. IEHP and its Delegates must have processes in place to determine when Members have other health coverage (OHC).

C. It is the responsibility of IEHP and its Delegates to utilize their clinical judgement and ensure that Members do not experience barriers accessing timely care for Medi-Cal covered services due to coordination with a Member's OHC.

D. Regardless of the presence of OHC, IEHP and its Delegates must ensure Providers do not refuse to provide a covered Medi-Cal service to a Medi-Cal Member.[3]

DEFINITIONS:

A. Provider – For the purpose of this policy, Providers include Physicians, Advanced Practice Practitioners, Behavioral Health Providers and Ancillary Providers.

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

PROCEDURES:

A. IEHP and its Delegates must ensure its Providers verify the Member's eligibility for the presence of OHC prior to delivering services to Member.[4]

   1. Medi-Cal eligibility information, including OHC are provided by IEHP through the secure IEHP Provider web portal at www.iehp.org.

   2. When a Provider verifies a Member's eligibility through the secure IEHP Provider web portal prior to providing services, the Eligibility Verification page will indicate whether the Member has OHC and provide available OHC details. A link to the AEVS portal is also available on www.iehp.org.

B. Once it is determined that there is no OHC or that coordinating with the Member's OHC could

[1] California Welfare and Institutions Code (Welf. & Inst. Code) § 14124.90
[2] Title 22, California Code of Regulations (CCR) § 50763(a)(3)
[3] Title 42, United States Code §1396a(a)(25)(D)
[4] Department of Health Care Services (DHCS) All Plan Letter (APL) 21-002 Supersedes Policy Letter (PL) 08-011, "Cost Avoidance and Post-Payment Recovery for Other Health Coverage"

cause a delay in care, IEHP and its Delegates will process the referral authorization request following their prior authorization process. See Policy 14D, "Pre-Service Referral Authorization Process." ~~for more information.~~

C. If it is determined that there is OHC present that covers the requested service and that coordinating with the Member's OHC will not cause a delay in care for the Member, then IEHP and its Delegates will cancel the request in their medical management system and notify the requesting provider only in writing that the request be coordinated with the Member's OHC. This IEHP-approved notification template is available online at www.iehp.org.

D. The Denial Notice of Action (NOA) template is available on the Provider Portal at www.iehp.org, under the 'Forms" section. The NOA would only be sent to Members/Providers if the requesting provider submits proof that the request is no longer covered or has been exhausted by the OHC and the request does not meet clinical guidelines.

E. For IEHP and its Delegates to consider benefit coverage, proof that all sources of payment have been exhausted must be documented. Acceptable forms of such proof include:[5]

1. A denial letter from the OHC for the service; or
2. An explanation of benefits indicating that the service is not covered by the OHC.

F. The Member to whom services were provided is not liable for any portion of the bill, except non-benefit items or non-covered services.[6]

G. This OHC policy does not apply for Members that may have workers compensation or other third-party liability insurance related to accidental injuries. ~~Please~~ See Policy 20F, "Coordination of Benefits." ~~for more information.~~

Monitoring and Oversight

A. IEHP will monitor Delegates' adherence to this policy through its monthly delegation oversight process. Please see Policies 25E1, "Utilization Management Delegation and Monitoring" and 25E2, "Utilization Management Reporting Requirements."

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2020
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2022

[5] DHCS APL 21-002
[6] 22 CCR § 1300.71

14. UTILIZATION MANAGEMENT

B. Second Opinions

APPLIES TO:

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

POLICY:

A. IEHP and its IPAs provide for Member's 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.[1,2,3]

PROCEDURES:

Requesting Second Opinion

A. Primary Care Providers (PCPs) and Specialists may request a second opinion from the Member's IPA regarding proposed medical or surgical treatments from an appropriately qualified participating healthcare professional.

B. Members should request a second opinion through their PCP or Specialist. If the PCP or Specialist refuses to submit a request for a second opinion, the Member can submit a grievance or a request for assistance through IEHP Member Services at (800) 440-4347. IEHP's Member Services staff directs the Member to 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.[4] ~~Please~~ See Policy 25E1, "Utilization Management Delegation and Monitoring." ~~for more information.~~

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.[5]

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management
[2] California Health and Safety Code (Health & Saf. Code) § 1383.15
[3] National Committee for Quality Assurance (NCQA), ~~2021~~ 2022 Health Plan Standards and Guidelines, MED 1, Element C
[4] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
[5] CA Health & Saf. Code § 1383.15(c)

Authorizing Second Opinion Requests

A. Reasons for providing or authorizing a second opinion include, but are not limited to, the following:[6]

1. The Member questions the reasonableness or necessity of recommended surgical procedures;
2. The Member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment including but not limited to a serious chronic condition;
3. Clinical indications are not clear or are complex and confusing, a diagnosis is questionable due to conflicting test results, or the treating 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.[7,8]

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 within the IPA's network.[9,10]

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.[11,12]

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.[13] Please see Policy 9C, "Non-Emergency Medical and Non-Medical Transportation Services."

F. IEHP and its IPAs require the second opinion Provider to provide to the Member and initial Provider consultation reports, including any recommended procedures or tests that the second

[6] CA Health & Saf. Code § 1383.15(a)
[7] CA Health & Saf. Code § 1383.15(e)
[8] NCQA, ~~2021~~ 2022 HP Standards and Guidelines, MED 1, Element C
[9] CA Health & Saf. Code § 1383.15(f)
[10] NCQA, ~~2021~~ 2022 HP Standards and Guidelines, MED 1, Element C
[11] CA Health & Saf. Code § 1383.15(g)
[12] NCQA, ~~2021~~ 2022 HP Standards and Guidelines, MED 1, Element C
[13] CA Health & Saf. Code § 1383.15(g)

opinion Provider believes appropriate.[14] 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 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, alternative care recommendations, and information on how to appeal this decision.[15]

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). Please see Policy 14A1, "Review Procedures – Primary Care Provider Referrals" for more information.

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 the timeframes described in this policy (See Attachment, "Second Opinion Tracking Log" in Section 25). See Policy 25E2, "Utilization Management - Reporting Requirements" for more information.

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.

[14] CA Health & Saf. Code § 1383.15(h)
[15] CA Health & Saf. Code § 1383.15(i)

14. UTILIZATION MANAGEMENT

C. Emergency Services

APPLIES TO:

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

POLICY:

A. IEHP covers and reimburses, without prior authorization, hospital emergency department or emergency physicians for all professional, physical, mental, and substance use treatment services, screening examinations necessary to determine the presence or absence of an emergency medical condition, and if an emergency medical condition exists, for all services medically necessary to stabilize the Member regardless of whether the services are performed by an in-network Provider.[1,2,3,4,5,6,7]

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

DEFINITIONS:

A. Emergency medical condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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:[8,9,10,11]

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.

[1] Title 22 California Code of Regulations § 53855(a)
[2] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 7, Emergency Care
[3] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 8, Provision 13, Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization
[4] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization
[5] National Committee for Quality Assurance (NCQA), ~~2022~~ 2023 Health Plan (HP) Standards and Guidelines, MED 9 Element D, Factor 1
[6] DHCS All Plan Letter (APL) 22-005, "No Wrong Door for Mental Health Services Policy"
[7] DHCS APL 23-009, Authorizations for Post-Stabilization Care Services
[8] Title 42, Code of Federal Regulations (CFR) § 438.114
[9] California Health and Safety Code (Health & Saf. Code) § 1317.1(b)
[10] NCQA, ~~2022~~ 2023 HP Standards and Guidelines, MED 9 Element D, Factor 1
[11] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 1, Definitions

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:[12]

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.[13] This includes all professional, physical, mental, and substance use treatment services, screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medication exists, for all services medically necessary to stabilize the Member.

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

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.[14]

B. The financial responsibility associated with the diagnosis and/or treatment of a Member's visit to an ED is as follows:

1. IPAs are financially responsible for:
    a. All professional fees associated with the diagnosis and/or treatment of an ED visit when the Member has an emergency medical condition;
    b. All professional components of an ED;
    c. The professional components of the MSE; and
    d. Facility components as per the IPA's contractual agreement with IEHP.
2. IEHP is financially responsible for:
    a. All facility and technical fees; and
    b. The facility and technical components of the MSE.

[12] CA Health & Saf. Code § 1317.1(k)
[13] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 1, Definitions
[14] https://www.aafp.org/afp/2007/0601/p1679.html

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. 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.[15,16,17]

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.[18,19]

C. IEHP ~~and its IPAs~~ shall make every effort to respond to requests for necessary post-stabilization medical care within thirty (30) minutes of receipt. ~~In the event~~

D. IEHP is financially responsible for post-stabilization care services in the event that the Plan:[20,21,22,23]

1. ~~or its IPA~~ ~~is unable to D~~be ~~contacted, or d~~oes not respond to a request for pre-approval within the timeframe allotted~~,~~;

2. Cannot be contacted; or

[15] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 8, Provision 13, Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization
[16] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 7, Emergency Care
[17] NCQA, ~~2022~~ 2023 HP Standards and Guidelines, MED 9 Element D, Factor 3
[18] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 6, Provision 9, Plan Physician Availability
[19] NCQA, ~~2022~~ 2023 HP Standards and Guidelines, MED 9 Element D, Factor 2
[20] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization
[21] Title 28, California Code of Regulations (CCR) § 1300.71.4(b)
[22] NCQA, 2023 HP Standards and Guidelines, MED 9 Element D, Factor 3
[23] DHCS APL 23-009

3. Cannot reach an agreement with the treating Provider concerning the Member's care and a Plan physician is not available for consultation~~the services are considered approved~~.[24][25][26][27]

All subsequent days are subject to review for medical necessity.

E. If IEHP 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 physician is able to be consulted and one of the following criteria is met:[28]~~:~~

1. An IEHP physician with privileges at the emergency physician's hospital assumes responsibility for the Member's care;
2. An IEHP physician assumes responsibility for the Member's care through transfer;
3. The IEHP 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 are documented in IEHP's medical management system 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 representative responding to the request.

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

~~E.~~H. If IEHP 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.[29]

~~F.~~I. IPAs are encouraged to develop contractual arrangements with EDs and physician groups. IPAs with contractual arrangements with EDs differing from this policy are subject to the division of financial responsibility guidelines described above in the event of disputed claims appealed to IEHP.

~~G.~~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.[30]

---

[24] ~~DHCS IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization~~
[25] ~~Title 28, California Code of Regulations (CCR) § 1300.71.4(b)~~
[26] ~~NCQA, 2022 HP Standards and Guidelines, MED 9 Element D, Factor 3~~
[27] ~~DHCS APL 23-009~~
[28] DHCS APL 23-009~~Ibid.~~
[29] 28 CCR § 1300.71.4(c)
[30] CA Health & Saf. Code § 1262.8(j)

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revision Date:**	~~January~~ May ~~1~~3, ~~2022~~2023

14. UTILIZATION MANAGEMENT

D. Pre-Service Referral Authorization Process

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal 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.[2]

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;[3]
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,

[1] California Health and Safety Code (Health & Saf. Code) § 1367.01
[2] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 1, Definitions
[3] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provisions 3, Timeframes for Medical Authorization

handwritten initials, unique electronic identifier, or electronic signatures that can demonstrate appropriate controls to ensure that only the individual indicated may enter a 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.[4] See Policy 14A1, "Primary Care Provider (PCP) Referrals."

IEHP and Delegate Responsibilities

A. IEHP and its Delegates must inform contracted and non-contracted providers of their referral and prior authorization process at the time of referral.[5] 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.

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

1. Verification of Member eligibility by the Delegate;
2. Verification of presence of other health coverage (see Policy 14A3, Review Procedures – Other Health Coverage);
3. Written documentation by the referring Provider of medical necessity for a service, procedure, or referral;
4. Verification by the Delegate that the place of service and requested Provider is within the IEHP network;
5. Assessment of medical necessity and appropriateness of level of care with determination of approval or denial of the proposed service or referral;

[4] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 13, Medical Records
[5] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management

6. Consulting with the referring Provider, when appropriate.[6]

C. 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.[7] See Policy 25E1, "Utilization Management – Delegation and Monitoring."

D. 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.[8] Please see Policy 25E1, "Utilization Management – Delegation and Monitoring."

E. IEHP and its Delegates must have a process that facilitates the Member's access to needed specialty care by prior authorizing, at a minimum, a consult and 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).

F. 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.[9]

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");[10, 11,12,13]
2. Family planning (see Policy 10G, Family Planning Services");[14,15]
3. Abortion services (see Policy 9E, "Access to Services with Special Arrangements");[16]

[6] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
[7] Ibid.
[8] Ibid.
[9] CA Health & Saf. Code § 1367.01
[10] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 7, Emergency Care
[11] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
[12] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization
[13] National Committee for Quality Assurance (NCQA), 2022 Health Plan (HP) Standards and Guidelines, MED 9, Element D, Factors 1 through 3
[14] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
[15] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 9, Access to Services with Special Arrangements
[16] DHCS APL 15-020 Supersedes PL 99-08, "Abortion Services"

4. Sexually transmitted infection (STI) diagnosis and treatment (see Policy 10H, "Sexually Transmitted Infection (STI) Services"); [17,18]
5. Sensitive and confidential services (see Policy 9E, "Access to Services with Special Arrangements");
6. HIV testing and counseling at the Local Health Department (See Policy 10I, HIV Testing and Counseling"); [19,20]
7. Immunizations at the Local Health Department (See Policy 10I, HIV Testing and Counseling");[21]
8. Routine OB/GYN Services, (including prenatal care by Family Care Practitioner (credentialed for obstetrics) within IEHP network;[22]
9. Out of area renal dialysis;[23]
10. Biomarker testing for advanced or metastatic stage 3 or 4 cancers;[24,25]
    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.[26]
11. Urgent care;[27] and
12. Preventive services,[28] which includes those listed in the Department of Health Care Services (DHCS) Medi-Cal Provider Manual- Preventive Services List,[29] as well as the following:

[17] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
[18] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 9, Access to Services with Special Arrangements
[19] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
[20] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 9, Access to Services with Special Arrangements
[21] DHCS All Plan Letter (APL) 18-004 Supersedes Policy Letter (PL) 96-013 and APL 07-015, "Immunization Requirements"
[22] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
[23] DHCS Medi-Cal Provider Manual, "Dialysis: End Stage Renal Disease Services"
[24] California Health and Safety Code (CA HSC) §1367.665
[25] DHCS APL 22-010 "Cancer Biomarker Testing"
[26] https://www.accessdata.fda.gov/scripts/cder/daf/
[27] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 4, Access Standards
[28] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
[29] https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/prev.pdf

a. Bone Density Screening (CPT codes: 77080 and 77081)

b. Diagnostic Mammograms for ages 40 and above (CPT codes: 77065, 77066 and 77063)

c. Lung Cancer Screening (CPT codes: S8032 and 71271)

H. IEHP will accept only the listed request types for continued services from contracted Durable Medical Equipment (DME) vendors. Approval will be based on medical guidelines and frequency limitations.

1. Oxygen supplies, they must have oxygen saturation levels on room air annually;
2. CPAP/BiPAP supplies;
3. Ostomy supplies;
4. Incontinent supplies;
5. Non disposable insulin pump supplies;
6. Enteral/Parenteral feeding pump supplies;
7. TENS unit supplies; and
8. Suction canisters.

I. 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, continue to monitor the Member's progress to ensure appropriate intervention and safe transition back into the network.

J. IEHP and its Delegates must authorize access to out-of-network providers in instances, including but not limited to the following:

1. The Plan does not meet network adequacy standards;[30]
2. The Plan does not have Alternative Access Standards approved by DHCS and does not meet network adequacy standards;
3. The Plan does not meet time or distance standards;
4. The Plan is unable to meet requirements for timely access to appointments; and
5. The Provider type is unavailable within the Plan's service area and within adjoining counties; and
6. The Plan does not have in-network Long Term Care capacity.

[30] CA Welfare and Institutions (Welf. & Inst.) Code § 14197

K. 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).[31] See Policy 25E1, "Utilization Management - Delegation and Monitoring."

L. 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):[32]

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

~~L.~~M. In the event a Specialist is terminated voluntarily or as directed by IEHP, the IPA coordinates the redirection of the Members' care, as needed.[33]

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;[34] 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 the Peer Review Subcommittee.

[31] Title 42 Code of Federal Regulations (CFR) §§ 438.210, 422.568, 422.570, and 422.572
[32] CA Health & Saf. Code § 1367.01(e)
[33] DHCS APL 21-003 Supersedes APL 16-001, "Medi-Cal Provider and Subcontractor Terminations"
[34] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 4, Review of Utilization Data

14. UTILIZATION MANAGEMENT

D. Pre-Service Referral Authorization Process

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

14. UTILIZATION MANAGEMENT

E. Referral Procedure for ~~Custom Wheelchairs and~~ Powered Mobility Devices

APPLIES TO:

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

POLICY:

A. IEHP and its IPAs ensure that medically necessary Durable Medical Equipment (DME) is provided to Members in a timely manner. Specifically, for wheelchairs and seating and positioning components, medical necessity criteria will include the medical evaluation of the Member and review of such equipment to ensure the Member is able to have appropriate mobility in or out of home.[1,2]

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.[3]~~

~~B.~~A. 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 in required for professionals working in seating, positioning and mobility.[4]

PROCEDURES:

IPA Responsibilities

A. IEHP and its IPAs are responsible for authorizing purchases, rentals and repairs of custom and non-custom (manual) wheelchairs.

B. Prior to the submission of a request to IEHP for the purchase of a ~~custom wheelchair/~~powered mobility device, the IPA must ensure the Member undergoes a 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.[5,6]

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 15-018, "Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components"
[2] DHCS Medi-Cal Provider Manual, "Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines"
~~[3] Title 22, California Code of Regulations (CCR) § 51321~~
[4] DHCS APL 15-018
[5] Ibid.
[6] DHCS Medi-Cal Provider Manual, "Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines"

C. The IPA Medical Director must review requests for ~~custom wheelchair/~~powered mobility devices prior to submission to IEHP. If the IPA determines that based on the functional/safety evaluation the request meets criteria, the IPA will forward the referral to IEHP for determination.

1. The IPA must submit the referral ~~to IEHP~~ via the secure IEHP Provider portal no later than one (1) business day from the IPA's decision.

~~2. The referral formrequest must be faxed to IEHP's Utilization Management (UM) department at (909) 890-5751 for review and coordination of services (See Attachment, "Health Plan Referral Form for Out-of-Network and Special Services" in Section 14).submitted via the IEHP Provider Portal.~~

~~3.~~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.

D. If the IPA determines that based on the functional/safety evaluation, the request does not meet criteria, the IPA shall issue the Denial Notice of Action (NOA) letter to the Member and Provider. IEHP-approved NOA templates are available online at www.iehp.org.

IEHP Responsibilities

A. IEHP's UM department will review the referral and supporting documentation. Determinations are made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Providers (see Attachment, "UM Timeliness Standards – Medi-Cal" in Section 14).[7] Please refer to Policy 25E1, "Utilization Management Delegation and Monitoring" for more information on timeliness standards.

B. IEHP will provide notification to the IPA, requesting Provider, and PCP regarding the determination.

C. If the IPA does not submit a thorough functional/safety evaluation to support the medical necessity of the requested ~~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.

D. 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.

[7] DHC)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures

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.

F. IEHP is responsible for all repairs and maintenance of purchased ~~custom wheelchairs/~~powered mobility devices. If an IPA receives a request for such services, the referral must be forwarded to the IEHP UM department ~~at (909) 890-5751~~ via the IEHP Provider Portal within one (1) business day of receipt of the request.

Chief Title: Chief Medical Officer	**Revision Date:**	January 1, ~~2022~~2023

14. UTILIZATION MANAGEMENT

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

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal 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.[1,2]

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. Financial responsibility for Medi-Cal Members under age 21 or residing in Intermediate Care Facilities for Developmentally Disabled (ICF-DD) continues to reside with IEHP and the Member's IPA until the date the Member is disenrolled from IEHP to Medi-Cal Fee-For-Service (FFS).[3]

PURPOSE:

A. To promote the appropriate placement of Members into long-term care when services cannot be provided in environments of lower levels of care or as an appropriate plan for transition from the hospital.

B. To 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.[4,5]

B. Custodial Care – Consists of non-medical care that can reasonably and safely be provided by

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 17-017 Supersedes APL 03-003, "Long Term Care Coordination and Disenrollment"
[2] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 21, Provision7, Covered Services
[3] DHCS APL17-017
[4] Ibid.
[5] 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

non-licensed caregivers and involves help with daily activities like bathing and dressing.

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 admitted directly from the community. For information on skilled level LTC, please see Policy 14F2, "Long Term Care – Skilled Level."

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).[6] See Policy 14D, "Pre-Service Referral Authorization Process" for more information.

C. Within 48 hours of the Member's admission, the LTC facility must submit to the IEHP all clinical documentation that demonstrate the medical necessity of the inpatient admission, including the Preadmission Screening and Resident Review (PASRR)[7]. If clinical documents are not received timely, the inpatient admission will be at risk for potential denial.

1. For admissions from the community: The LTC facility must complete the PASRR upon admission and submit to the IEHP along with clinical documentation.

2. For admissions from General Acute Care Hospitals (GACH): The LTC facility must ensure that the Preadmission Screening (PAS) has been completed prior to admitting. After admission from GACH, the LTC facility must complete the Resident Review (RR) and submit to IEHP along with clinical documentation.

D. 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. 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.

E. 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:[8]

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.

[6] Title 42 Code of Federal Regulations (CFR) §§ 438.210, 422.568, 422.570, and 422.572
[7] DHCS APL 23-004 Supersedes APL 22-018, "Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care"
[8] 42 CFR §483.15 (d)

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.[9]

~~D.~~F. 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.[10]

~~E.~~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.

IEHP, IPA & PCP Responsibilities

A. IPAs are responsible for forwarding to IEHP all requests for custodial level 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, 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.

C. 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.

D. IEHP collaborates with facilities to ensure that Members are placed in the appropriate level of care within network adequacy standards set forth by the Department of Health Care

[9] 42 CFR §483.15 (e)(1)
[10] 42 CFR §483.15 (e)(1)(ii)

Services (DHCS).[11,12] IEHP ensures sufficient network capacity to enable placement in SNFs within the following timeframes:

1. Riverside – Within seven (7) business days
2. San Bernardino – Within fourteen (14) calendar days

E. 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:[13]

1. Skilled Nursing Facility - Section 51124
2. Subacute Level of Care - Section 51124.5
3. Pediatric Subacute Care Services - Section 51124.6
4. Intermediate Care Services - Section 51120

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

G. Concurrent review begins at admission and may be performed telephonically or onsite by chart review. Continued and subsequent reviews are performed using IEHP-approved authorization criteria. Please 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 every three (3) months until discharge, unless directed otherwise by the IEHP LTC Review Nurse.
2. Timely submission of clinical progress notes is required 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 custodial days. IEHP will review and make the best clinical decision possible based on the clinical documentation provided by the LTC facility (see Attachments, "Long-Term Care (LTC) Initial Review Form" and "Long-Term Care (LTC) Follow-Up Review Form" in Section 14).
3. Discharge planning should begin once the Member has been determined ready for lower level of care. IEHP must be informed of any discharge needs requiring authorization as soon as need is known but no later than prior to day of discharge (see Attachment, "Service Request Form for Skilled Nursing Facilities" in Section 14).

[11] DHCS APL 21-006 Supersedes APL 20-003, "Network Certification Requirements," Attachment A.
[12] DHCS APL 23-004
[13] Title 22 California Code of Regulations (CCR) § 51124

H. The Member's IPA, PCP and CM are responsible for the coordination of the Member's medical needs while inpatient for the month of enrollment into IEHP or admission to custodial care and month after, or until Member transfers into IEHP Direct.

I. IEHP must assess and estimate a length of stay for the Member as soon as possible after admission.[14]

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

K. 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.

L. IEHP will authorize bed holds as follows:[15]

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 that 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.

M. IEHP will notify the Member thirty (30) calendar days in advance of pending PCP change and/or IPA reassignment, if the Member is expected to exceed the month of admission and month following in LTC-Custodial Level.

1. If the Member agrees, the PCP change and/or IPA reassignment will be implemented. If the Member does not agree, they will instead remain with their current PCP and/or IPA. The Member remains in LTC-Custodial Level whether or not they agree to the PCP change and/or IPA reassignment.
2. Upon discharge from custodial level LTC, the Member will be reassigned to their original PCP and IPA.

N. Prior to being in custodial level LTC for ninety (90) calendar days, IEHP will request a copy of the completed MC171 form (if not already received) with the date it was submitted to the local agency (See Attachment, "MC171 Form and Instruction 05-07" in Section 14).

[14] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 21, Provision7, Covered Services
[15] DHCS Medi-Cal Provider Manual, "Leave of Absence, Bed Hold, and Room and Board"

O. IEHP authorizes Leave of Absence (LOA) as follows:[16,17]

1. LOA will be authorized for up to seventy-three (73) days per calendar year for Members with developmental disabilities and eighteen (18) days per calendar year for all other Members.
2. Up to twelve (12) additional days of LOA may be approved per calendar year in increments of no more than two (2) consecutive days. The additional days of LOA must be in accordance with the Member's care plan and appropriate to the mental and physical well-being of the Member.
3. At least five (5) days of LTC inpatient care must be provided between each approved LOA.

P. IEHP does not require new Members residing in out-of-area/out-of-network LTC to relocate unless it is determined that relocation is medically necessary or if the out-of-area/out-of-network LTC facility does not meet the requirements for continuity of care, as outlined in Policy 12A2, "Care Management Requirements - Continuity of Care."

Q. 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. Accommodation codes will require an authorization within the inpatient authorization.
3. All accommodation codes are approved on a case-by-case basis after review of supporting clinical documentation.
4. Accommodation code 560 does not apply to the use of alcohol and marijuana.

R. IEHP and the Member's IPA Care Manager are responsible for assessing whether a Member may be eligible for the Nursing Facility (NF) Waiver Program, in consultation with the Member's family, as necessary. IEHP or the Member's IPA facilitates the application for the waiver as outlined in Policy 12P, "Home and Community-Based Alternatives Waiver Program."

1. The Member's IPA remains financially responsible for professional services until the Member is accepted into the NF Waiver Program.
2. If LTC continues and the Member is not accepted into the NF Waiver Program, the IPA and PCP remain responsible for all necessary care and care management until the Member is disenrolled to FFS.

[16] 22 CCR § 51535
[17] DHCS Medi-Cal Provider Manual, "Leave of Absence, Bed Hold, and Room and Board"

R. IEHP utilizes a Long-Term Services and Supports (LTSS) Liaison to assist facilities in addressing claims and payment inquiries and assist with care transitions among the LTC Provider community to best support Members' needs[18]. The IEHP LTSS Liaison is:

1. Ben Jauregui – Manager, Behavioral Health & Care Management

   Jauregui-B@iehp.org

   909-296-3533

S. Effective January 1st 2023, for Members residing in a SNF and transitioning from Medi-Cal fee-for-service (FFS) to IEHP, the following applies:

1. IEHP will honor treatment authorization requests (TARs) approved by DHCS for SNF Services provided under the SNF per diem rate for a period of twelve (12) months after enrollment into IEHP or the duration of the approved TAR, whichever is shorter.
2. IEHP will honor all other DHCS-approved TARs for services in a SNF exclusive of the SNF per diem rate for a period of ninety (90) days after enrollment into IEHP, or until IEHP is able to reassess the Member and ensure provision of medical necessary services.

[18] DHCS APL 23-004

14. UTILIZATION MANAGEMENT

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

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	July 1, 2013
Chief Title: Chief Medical Officer	**Revision Date:**	May 12, 2023

14. UTILIZATION MANAGEMENT

F. Long Term Care
2. Skilled Level

APPLIES TO:

A. This policy applies for all IEHP Medi-Cal 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.[1,2]

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.

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

D. IEHP will only disenroll Members in these scenarios:[3]

1. Member, who is under the age of 21, has been in an intermediate care facility for persons with developmental disabilities (ICF-DD) for the month of admission and the month following; or
2. Member, who is between the ages of 22-64 years, was in an Institution of Mental Disease (IMD) upon enrollment and admission.

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.[4]

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 17-017 Supersedes APL 03-003, "Long Term Care Coordination and Disenrollment"
[2] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 21, Provision7, Covered Services
[3] DHCS APL 17-017
[4] Ibid.

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.[5]

PROCEDURES:

Skilled Level Long-Term Care and Provider Responsibilities

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 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 Medi-Cal" in Section 14).[6] 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 the 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 (LTC) – Custodial Level";
    c. Intermediate care (based upon the Member's benefit);

[5] 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
[6] Title 42 Code of Federal Regulations (CFR) §§ 438.210, 422.568, 422.570, and 422.572

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 treatment plans.

D. Within 48 hours of the Member's admission, the LTC facility must submit to the IEHP all clinical documentation that demonstrate the medical necessity of the inpatient admission, including the Preadmission Screening and Resident Review (PASRR)[7]. If clinical documents are not received timely, the inpatient admission will be at risk for potential denial.

1. For admissions from the community: The LTC facility must complete the PASRR upon admission and submit to the IEHP along with clinical documentation.

2. For admissions from General Acute Care Hospitals (GACH): The LTC facility must ensure that the Preadmission Screening (PAS) has been completed prior to admitting. After admission from GACH, the LTC facility must complete the Resident Review (RR) and submit to IEHP along with clinical documentation.

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:[8]

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:

[7] DHCS APL 23-004 Supersedes APL 22-018, "Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care"
[8] 42 CFR §483.15 (d)

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.[9]

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.[10]

~~G.~~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. 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.

~~H.~~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.

IEHP, IPA and 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

[9] 42 CFR §483.15 (e)(1)
[10] 42 CFR §483.15 (e)(1)(ii)

for LTC facility placement of Members with assistance from the Member's IPA Case Management (CM) department, as needed.

F. IEHP collaborates with facilities to ensure that Members are placed in the appropriate level of care within network adequacy standards set forth by the Department of Health Care Services (DHCS).[11,12] IEHP ensures sufficient network capacity to enable placement in SNFs within the following timeframes:

1. Riverside – Within seven (7) business days
2. San Bernardino – Within fourteen (14) calendar days

G. 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:[13]

1. Skilled Nursing Facility - Section 51124
2. Subacute Level of Care - Section 51124.5
3. Pediatric Subacute Care Services - Section 51124.6
4. Intermediate Care Services - Section 51120

H. 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. If none are available, either the Member's IPA or IEHP, based on financial responsibility, shall initiate a letter of agreement (LOA) 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 for Members remaining in LTC.

I. Authorization details will be available for the facility to view on the secure IEHP Provider portal once facility face sheet, admission orders, MC171 form, and if indicated, inter-facility transfer form have been received by IEHP (See Attachment "MC 171 Form and Instruction 05-07" in Section 14). Non-contracted facilities are provided authorization details verbally.

J. 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. Please see Policy 25E1, "Utilization Management – Delegation and Monitoring" for more information.

[11] DHCS APL 21-006 Supersedes APL 20-003, "Network Certification Requirements," Attachment A.
[12] DHCS APL 23-004
[13] Title 22 California Code of Regulations (CCR) § 51124

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).

K. Reviews should include physician communication and ongoing communication with other healthcare professionals involved in the Member's care as necessary. IEHP 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.

L. 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.

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

N. 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).

O. All stays greater than the month of admission and the month after are the responsibility of IEHP. IPAs must notify IEHP of Members who are receiving skilled care as of the previous month by faxing the Long-Term Care (LTC) Data Sheet along with the face sheet to (909) 912-1045.

P. IEHP will notify the Member thirty (30) days in advance of any pending PCP and/or IPA re-assignment, if the Members is expected to exceed the month of admission and month following.

1. If the Member agrees, the PCP change and/or IPA reassignment will be implemented. If the Member does not agree, they will instead remain with their current PCP and/or IPA. The Member remains in LTC-Skilled Level whether or not they agree to the PCP change and/or IPA reassignment.

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

1. 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."[14]

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.

U. IEHP utilizes a Long-Term Services and Supports (LTSS) Liaison to assist facilities in addressing claims and payment inquiries and assist with care transitions among the LTC Provider community to best support Members' needs[15]. The IEHP LTSS Liaison is:

1. Ben Jauregui – Manager, Behavioral Health & Care Management

   Jauregui-B@iehp.org

   909-296-3533

V. Effective January 1st 2023, for Members residing in a SNF and transitioning from Medi-Cal fee-for-service (FFS) to IEHP, the following applies:

1. IEHP will honor treatment authorization requests (TARs) approved by DHCS for SNF Services provided under the SNF per diem rate for a period of twelve (12) months after enrollment into IEHP or the duration of the approved TAR, whichever is shorter.

[14] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 21, Provision 7, Covered Services
[15] DHCS APL 23-004

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	July 1, 2013
Chief Title: Chief Medical Officer	**Revision Date:**	May 12, 2023

14. UTILIZATION MANAGEMENT

G. Acute Inpatient Admission and Concurrent Review

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members and living donors to IEHP Members for the purposes of major organ transplant (MOT).

POLICY:

A. IEHP has 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 ensures 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.[2]

PURPOSE:

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

PROCEDURES:

Hospital/Facility Responsibilities

A. Contracted and non-contracted Hospitals and LTAC facilities must notify IEHP upon a Member's planned or unplanned inpatient admission or as soon as the facility deems the need ~~for inpatient admission~~ to obtain authorization for the inpatient stay. If circumstances do not allow for more timely notification, ~~Contracted hospitals must to use secure email or data exchange to inform IEHP of any hospital admission for all Members. C~~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 ~~if circumstances do not allow for more timely notification~~.

~~A.~~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. ~~At the latest, notifications must be made prior to, or at the time of the Member's discharge or transfer from inpatient servies~~ Such notification may be done via fax at (909) 477-8553, phone or electronic health record data exchange. Non-contracted facilities can notify IEHP of admission 24 hours

[1] California Health and Safety Code (Health & Saf. Code) § 1367.01
[2] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 2, Discharge Planning and Care Coordination

a day by phone at 866-649-6327.

1. Hospitals do ~~not~~ need to supply IEHP a notification of admission for standard obstetric (OB) deliveries. However, n~~N~~o 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:[3]

   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.

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

~~C.~~D. The Hospital or LTAC facility must begin discharge planning upon admission and inform IEHP of any discharge needs that may require 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).

1. Discharge planning is also extended to individuals, who may not be enrolled in IEHP Medi-Cal but serve as a living organ donor to a IEHP Member.

~~D.~~E. Discharge planning must ensure that necessary care, services, and supports are in place in the community for the Member once they are discharged from the Hospital or LTAC, including scheduling an outpatient appointment and/or conducting follow-up with the Member and/or caregiver. For Medi-Cal SPD Members, discharge planning must include, at minimum:[4]

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 by the Member or their representative, physical and mental function, 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 or home recommended by the facility and agreed to by the Member or their representative, and pre-discharge counseling

[3] Title 45 Code of Federal Regulations (CFR) §146.130
[4] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 2, Discharge Planning and Care Coordination

recommended;

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 contemplated by the Hospital or LTAC facility.

~~E.~~F. The Hospital or LTAC facility must submit all clinical documentation within one (1) business day post-discharge. 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.

~~F.~~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 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.

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

IPA Responsibilities

A. If directly notified by a Hospital or LTAC facility of an inpatient admission, IPAs must immediately notify the IEHP Utilization Management (UM) department.

~~A.~~B. Starting at admission, IPAs must collaborate with the hospital and IEHP to ensure ~~appropriate discharge planning~~that all discharge needs of the Member are met.

IEHP & PCP Responsibilities

A. IEHP performs admission review within one (1) business day of knowledge of admission.

B. IEHP performs concurrent review daily for per diem contracts or based on clinical criteria for All Patient Refined Diagnosis Related Group (APR-DRG) until discharge. Concurrent review may be performed either on-site by chart review or telephonically.

C. 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.[5] Please see Policy 25E1, "Utilization Management Delegation and Monitoring" for more information on authorization process

[5] CA Health & Saf. Code § 1367.01

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.

D. If IEHP 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.[6] Please see Section 16, "Grievance and Appeal Resolution System" for more information.

E. For denials of care or service, IEHP notifies the Hospital/Facility verbally within twenty-four (24) hours of the 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.

~~E.~~F. 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

~~F.~~G. Chronic, complex, high risk, high cost readmissions or catastrophic cases are referred for potential care management.

~~G.~~H. IEHP and its IPAs must ensure that Provider-Preventable Conditions (PPCs) are reported to the California Department of Health Care Services.[7,8,9] See Policy 13D, "Reporting Requirements Related to Provider Preventable Conditions."

[6] CA Health & Saf. Code § 1367.01
[7] Title 42, Code of Federal Regulations (CFR) § 438.3
[8] DHCS All Plan Letter (APL) 17-009 Supersedes APL 16-011, "Reporting Requirements Related to Provider Preventable Conditions
[9] Ibid.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	July 1, 2015
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

14. UTILIZATION MANAGEMENT

H. Hospice Services

APPLIES TO:

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

POLICY:

~~B.~~A. IEHP ensures timely access to hospice care services for Members, who are terminally ill, by covering these services without requiring prior authorization except for general inpatient care.[1]

DEFINITION:

~~B.~~A. Hospice Care – A medical multidisciplinary care designed to meet the unique needs of terminally ill individuals. It is used to alleviate pain and suffering and treat symptoms rather than cure the illness. Items and services are directed toward Member and family's physical, and psychosocial, social, and spiritual needs. Medical and nursing services are designed to maximize the Member's comfort, alertness, and independence so that the Member can reside in the home as long as possible.[2,3]

~~C.~~B. Terminally Ill – This means that an individual has a medical prognosis that his or her life expectancy is six (6) months or less if the illness runs its normal course.[4]

PROCEDURES:

Hospice Care

A. Hospice care is a covered optional benefit under Medi-Cal, which includes, but is not limited to the following services:[5]

1. Nursing services;
2. Physical, occupational, or speech–language pathology;
3. Medical social services under the direction of the physician;
4. Home health aide and homemaker services;

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 13-014 Supersedes APL 07-014, "Hospice Services and Medi-Cal Managed Care"
[2] DHCS Medi-Cal Provider Manual, "Hospice Care"
[3] Title 42, Code of Federal Regulations (CFR) § 418.3
[4] DHCS APL 13-014
[5] Ibid.

5. Medical supplies and appliances;
6. Drugs and biologicals;
7. Physician services;
8. Counseling services related to the adjustment of the Member's approaching death;
9. Continuous nursing services may be provided on a twenty-four (24) hour basis only during period of crisis and only as necessary to maintain the terminally ill Member at home;
10. Inpatient respite care provided on an intermittent, non-routine, and occasional basis for up to five (5) consecutive days at a time in a hospital, skilled nursing or hospice facility;
11. Short-term inpatient care for pain control or symptom management, which cannot be managed in the home setting; and
12. Any other palliative item or service for which payment may otherwise be made under the medical program and that is included in the hospice plan of care.

B. There are four (4) levels of hospice care:[6]

1. Routine home care;
2. Continuous home care requiring a minimum of eight (8) hours of care per twenty-four (24) hour period;
3. Respite care provided on an intermittent, non-routine and occasional basis for up to five (5) consecutive days at a time; and
4. General inpatient care for pain and symptom control or chronic symptom management, which cannot be managed in the Member's residence.

C. A Member may elect to receive hospice care during one or more of the following periods:[7,8]

1. Two (2) ninety (90) day periods, beginning on the date of hospice election; and
2. Followed by an unlimited number of sixty (60) day periods during the Member's lifetime.

D. A designated Primary Care Provider (PCP) or Specialist, if necessary, must have substantial involvement in the implementation of the home health, infusion, and hospice care management process.

E. Hospice care services may be initiated or continued in a home or clinical setting. Hospice care may be provided while the Member resides in a skilled nursing facility (SNF) or intermediate care facility (ICF). Hospice care services are not categorized as long-term care services regardless of the Member's expected or actual length of stay in a nursing facility

[6] DHCS APL 13-014
[7] DHCS Medi-Cal Provider Manual, "Hospice Care"
[8] DHCS APL 13-014

while also receiving hospice care. IEHP does not require authorization for room and board.[9]

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

Member Eligibility and Election of Services

A. Any Member certified by a Physician to be terminally ill that is, having a life expectancy of six (6) months or less may elect to receive hospice care in lieu of normal Medi-Cal coverage of services related to the terminal condition.[10]

B. Any Member younger than 21 years of age and certified by a Physician to be terminally ill, as defined in this policy, may elect to concurrently receive hospice care in addition to curative treatment of the hospice related diagnosis.[11,12,13]

C. Members who qualify for and elect hospice care services, including those in Long-Term Care, remain enrolled with IEHP while receiving such services.[14]

D. A Member's voluntary election may be revoked or modified at any time during an election period. To revoke the election of hospice care, the Member or Member's representative must file a signed statement with the hospice.

E. At any time after revocation, a Member may execute a new election, thus restarting the periods of care, as described in this policy.[15]

F. If a Member revokes the hospice benefit or is discharged by the hospice for cause and later elects hospice and is readmitted to the same or different hospice care Provider, then the election periods are initiated as if hospice is starting anew.[16]

Initiation of Hospice Care

A. IPAs that receive a request for hospice care must forward this immediately to IEHP by fax at (909) 297-2513.

B. The only requirement for initiation of outpatient hospice care services is a Physician's certification that a Member has a terminal illness, as defined in this policy, and a Member's "election" of such services.[17] A tracking number will be entered in the medical management system to assist with validation of supporting documentation requirements, i.e., initial Physician certification and Notice of Election. Additional certifications for illness periods (90-day period, subsequent 90-day period, or unlimited 60- day period) will be required for

[9] Ibid.
[10] DHCS Medi-Cal Provider Manual, "Hospice Care"
[11] Ibid.
[12] ~~Patient Protection and Affordable Care Act § 2302~~42 U.S. Code (USC) §1396d (o)(1)(C)
[13] DHCS APL 13-014
[14] Ibid.
[15] Ibid.
[16] Ibid.
[17] Ibid.

tracking purposes and coordination of services.

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

D. In the following scenarios, IEHP considers a one-time or ongoing contract with the established hospice care Provider until the new election period, or until the end of hospice services:

1. New Members receiving hospice at the time of their enrollment with IEHP may not be able to change their hospice care Provider even if requested due to limitations on the number of times there may be a change in the designation of a hospice care Provider during an election period; and/or

2. If it is determined that a change in hospice care Providers would be disruptive to the Member's care or would not be in the Member's best interest.

E. Only general inpatient hospice care is subject to prior authorization.[18] These requests must be submitted to IEHP to be processed as follows:

1. The referring Provider must determine the medical necessity for general inpatient level of care. The request must be submitted to IEHP via fax at (909) 297-2513 or secure Provider portal with the following:

   a. Certification of Physician orders for general inpatient hospice care; and

   b. Justification for this level of care.

2. IEHP will coordinate and arrange for authorized services with contracted hospice care Providers.

Hospice Care Provider Responsibilities

A. Upon request, hospice care Providers are required to make available to IEHP complete and accurate medical records which are signed and dated by appropriate staff and to permit access to all facilities records.

B. The hospice care Provider ensures all actions regarding the management of hospice services are documented. Documentation includes but is not limited to treatment, the Member's response to treatment, activities of daily living (ADL) issues, appointments, and any social concerns.

C. The hospice care Provider submits to IEHP via fax at (909) 297-2513 or secure Provider portal the initial written Certification of Terminal Illness (CTI) upon admission and no later than submission of the initial claim. For each subsequent recertification period, the hospice care Provider submits the CTI no later than the expiration of the current certification period. The CTI must contain the qualifying clause: "The individual's prognosis is for a life expectancy

[18] DHCS APL 13-014

of six months or less if the terminal illness runs its normal course." CTI recertification periods are as follows:

1. After the initial ninety (90)-day period;
2. After the subsequent ninety (90)-day period; and
3. After each subsequent sixty (60)-day period thereafter.

D. For the third benefit period recertification, and every re-certification thereafter, there must be a face-to face-encounter between the Member and the certifying provider no more than thirty (30) days prior to the certification date, to gather clinical findings to determine continued eligibility for hospice care.

1. A Face-to-Face encounter with the Member is required to determine eligibility and must be performed by hospice physician or hospice nurse practitioner. A hospice physician or NP who performs the encounter must attest in writing that he or she had a face-to-face encounter with the Member, including the date of the encounter.
2. The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled. Where a nurse practitioner performed the recertification, the attestation must state that the clinical findings of that visit were provided to the certifying physician for use in determining whether the Member continues to have a life expectancy of six months or less, should the illness run its normal course.
3. A hospice physician is a physician who is employed by or working under contracted with the hospice care Provider. A hospice nurse practitioner must be employed by the hospice care Provider. A hospice employee is one who receives a W-2 from or volunteers for the hospice care Provider.

E. The hospice care Provider is expected to complete the Physicians Orders for Life Sustaining Treatment (POLST) for 100% of IEHP Members admitted to hospice.

F. The hospice care Provider will ensure that for Members with a Full Code status, advanced care planning conversation is conducted and documented on at least a bi-weekly basis and at least monthly for all other Members.

G. As a standard of care, the hospice care Provider will ensure that the Hospice Interdisciplinary Group or Team reviews, revises and documents the individualized plan as frequently as the Member's condition requires, but no less frequently than every fifteen (15) calendar days.

H. When discharging a Member from hospice care due to patient expiration, the hospice care Provider must submit the Discharge Summary to IEHP within five (5) business days of the Member expiring. This may be sent to IEHP via fax at (909) 297-2513.

I. When discharging a Member due to revocation or ineligibility, the hospice care Provider must notify IEHP as soon as possible and no later than five (5) business days of revocation or known ineligibility to allow IEHP to coordinate the Member's care.

J. When a Member changes designation of hospice provider, the hospice shall provide transferring Member with a transfer summary including essential information relative to the patient's diagnosis, pain treatment and management, medications, medical treatments, dietary requirements, known allergies, treatment plan and previous hospice benefit information.

K. The hospice care Provider is required to participate in the Consumer Assessment of Healthcare Providers and Systems CAHPS® Hospice Survey and submit Hospice Item Set (HIS) data as required by the Centers for Medicare and Medicaid Services (CMS).

L. Hospice care Providers are expected to make available all four (4) levels of hospice care: Routine Home Care, Continuous Home Care, Inpatient Respite Care, General Inpatient Care.

M. When the Member's death is imminent, the hospice care Provider must conduct and document weekly visits. Refusal or rationale for not meeting this requirement must be documented accordingly.

N. Hospice care Providers will communicate with IEHP (either daily or weekly depending on the emergency) about the status of Members in Long Term Care (LTC) or any inpatient status during an emergency or crisis.

IEHP Responsibilities

A. IEHP staff responsibilities include the following utilization management and care coordination activities:

1. Verifying the Member's eligibility and benefits;
2. Utilizing approved guidelines to determine the appropriateness of the referral to home health, infusion, hospice services, or palliative care services;
3. Assessing informal resources that may be available (e.g., family, neighbors, etc.) and, when necessary, consulting with the county social services agencies or public authorities about available resources; and
4. Coordinating the referral with the PCP and hospice provider to assist with obtaining a Physician's order for hospice care.

B. IEHP coordinates the Member's care with the hospice care Provider and allows for the hospice interdisciplinary team to professionally manage the care of the Member.

C. Ongoing care coordination shall be provided to ensure that services necessary to diagnose, treat, and follow up on conditions not related to the terminal illness continue to be provided or are initiated as necessary.[19]

[19] DHCS APL 13-014

14. UTILIZATION MANAGEMENT

H. Hospice Services

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	July 1, 2014
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2022

14. UTILIZATION MANAGEMENT

I. My Path Palliative Care Program

APPLIES TO:

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

POLICY:

A. IEHP provides palliative care which consists of patient and family-centered care that optimizes quality of life by anticipating, preventing and treating suffering.[1] The provision of palliative care does not result in the elimination or reduction of any covered benefits or services and does not affect a Member's eligibility to receive any non-duplicative services, including home health services, for which the beneficiary would have been eligible.[2]

B. A Member with a serious illness who is receiving palliative care may choose to transition to hospice care if criteria is met. A Member 21 years or older may not be concurrently enrolled in Hospice care and Palliative Care.[3]

C. Through the My Path Program, IEHP has expanded the eligibility criteria to include other advanced illness conditions and expanded the benefit to include Medi-Cal and non-delegated Medicare Members.

D. Disputes related to the provision of palliative services will comply with regulatory grievance and appeal requirements. ~~Please~~ See Policy 16A, "Member Grievance and Appeals Resolution Process." ~~for more information.~~

PURPOSE:

A. To deliver high quality, medically necessary palliative services that is compliant with the California Department of Health Care Services (DHCS) standards.

B. To effectively communicate and educate the palliative benefit to IEHP Provider network and Membership.

C. To effectively monitor palliative care enrollment, network and utilization data.

DEFINITIONS:

A. Hospice Care - A benefit for terminally ill Members with a life expectancy of six (6) months or less and consists of interventions that focus primarily on pain ~~an~~and symptom management rather than ~~cure~~curative or prolongation of life.

B. Palliative Care – The Centers for Medicare and Medicaid Services (CMS) defines palliative care as: "patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves

[1] California Welfare and Institutions Code (WIC) § 14132.75 (a)
[2] Department of Healthcare Services (DHCS) All Plan Letter (APL) 18-020 Supersedes 17-015, "Palliative Care"
[3] Ibid.

addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice." Many physicians and practitioners note that palliative care is an overall approach to the practice of medicine that is broader than end-of-life care and is for "any age and any stage" of illness.[4] Palliative does not require the Member to have a life expectancy of six (6) months or less and may be provided concurrently with curative care.[5]

PROCEDURES:

A. **Program Overview**[6]

1. Palliative care services will include, at a minimum, the following services when medically necessary and reasonable for the palliative or management of a qualifying serious illness.
   a. **Advanced Care Planning (ACP):** To include documented discussions between a Physician or other qualified healthcare professional and the Member, family member, or legally recognized decision-maker. Counseling should address, but is not limited to, advanced directives and, for appropriate Members, Physician Orders for Life-Sustaining Treatment (POLST) forms and should include family conflict resolution over issues surrounding the Member's decisions. Family members who may wish to supersede the Member's goals of care should be identified, supported, and reconciled.
   b. **Palliative Care Assessment and Consultation**: Aimed at collecting routine medical data and personal information not regularly included in a medical history. Topics may include, but are not limited to:
      1) Treatment plan, including palliative care and chronic disease management;
      2) Pain and symptom management;
      3) Medication side effects;
      4) Emotional and social challenges;
      5) Spiritual concerns;
      6) Patient goals;
      7) Advance directive and/or POLST forms; and
      8) Legally recognized decision maker.
   c. **Individualized Written Plan of Care:** Developed with the engagement of the Member and/or his or her representative(s) in its design. If the Member already has

[4] ~~Department of Health Care Services' Senate Bill 1004 Medi-Cal Palliative Care Policy (November 2017).~~CA WIC, §14132.75 (a)(4)
[5] CA WIC § 14132.75 (a)
[6] DHCS APL 18-020

a plan of care, that plan should be updated to reflect any changes resulting from the palliative consultation or ACP discussion. The Member's plan of care must include all authorized palliative care, including but not limited to pain and symptom management and chronic disease management. The plan of care must not include services already received through another Medi-Cal funded benefit program.

d. **Pain and Symptom Management:** To include prescription medications, physical therapy, and other medically necessary services to address Member's pain and other symptoms.

e. **Mental Health and Medical Social Services:** Counseling and social services must be available to the Member to assist in minimizing the stress and psychological problems that arise from a serious illness. Services to include, but not limited to, psychotherapy, bereavement counseling, medical social services, and discharge planning. Particular attention and education will be given to the primary caregiver to prevent both unnecessary hospitalizations of the Member and unnecessary health harms to the caregiver from the role of caregiving. Provision of medical social services shall not duplicate specialty mental health services provided by the county and the Palliative Team shall work the Member, county, and IEHP in assisting with coordinating care as needed.

f. **Care Coordination:** Provided by a member of the Palliative Team ensuring continuous assessment of the Member's needs and implements the plan of care. The Palliative Team will regularly communicate plan of care with the Member's Primary Care Physician (PCP) through fax, verbal or integrated Electronic Medical Record (EMR). This communication should occur at a minimum of weekly intervals. The Palliative Team must be willing to address Member's immediate needs (e.g. pain and symptom management, durable medical equipment [DME] needs) in the event that the PCP is unavailable to avoid a delay in care.

g. **Palliative Care Team:** Will work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of Members and their families. The team members must provide all authorized palliative care. The team is to consist of:

1) Doctor of medicine or osteopathy;
2) Registered Nurse, Licensed Vocational Nurse, and/or Nurse Practitioner;
3) Social worker;
4) Chaplain;
5) Chaplain Services must be accessible as needed; and
6) 24/7 Telephonic Palliative Care Support.

2. IEHP will utilize qualified Providers for palliative care based on the setting and needs of the Members.

a. My Path Palliative Care Providers must comply with existing contracting and credentialing standards.

b. Providers authorized to provide services shall include licensed and accredited hospice agencies and home health agencies licensed to provide hospice care that are contracted with IEHP to provide palliative services.

c. Providers must be accredited by an IEHP recognized body or meet the IEHP standards of Provider network participation.

d. Hospice agencies and home health agencies contracted with IEHP to provide palliative services are expected to meet Members in a variety of settings depending on the needs of the Member. These include inpatient, outpatient, Community Based Adult Service centers, skilled nursing facilities, and home.

e. Palliative care provided in a Member's home must comply with requirements for in-home providers, services, and authorization, such as physician assessments and care plans.

f. Independent My Path Palliative Care Providers shall comply with IEHP's existing credentialing standards.

g. My Path Palliative Care Providers must demonstrate palliative care training and/or certification to conduct palliative care consultations or assessments.

3. IEHP will provide a network of Providers to offer palliative care services.

4. Medi-Cal IPAs should fax forward requests for community-based palliative care services directly to IEHP for review to (909) 890-5751. The IPA is to redirect the request on their end to IEHP. IEHP will use the original request date on the authorization request. IEHP will make the determination and send out all regulatory correspondence.

5. IEHP will educate and inform Members and network Providers of the availability of the palliative care benefit.

   a. Member notification and education will occur through a variety of channels including updating the Evidence of Coverage (EOC), Member newsletter communication, and website information.

   b. Provider notification and education will occur through a variety of channels including faxed notification, Provider Manual updates, Provider newsletter updates, website notification, and inclusion in Provider training materials.

B. **Program Criteria for Identification**

1. IEHP's My Path program requires that a Member meet all general criteria and at least one (1) disease-specific criteria. Refer to IEHP UM Subcommittee Approved Authorization Guidelines on My Path (A Palliative Care Approach) for the General and Disease-Specific eligibility criteria.[7] This is located on the web at www.iehp.org.

[7] DHCS APL 18-020

C. **Member Identification**

1. Eligible Members will be identified, assessed for program eligibility, and referred to the My Path Program through multiple means.[8]
   a. On a regular basis, IEHP will provide its My Path Palliative Care Provider network with a report that identifies Members with eligible diagnoses and determination of complexity and severity. The My Path Palliative Care Provider network shall reach out to these Members and perform an in-person clinical assessment for program eligibility.
   b. Members admitted to the inpatient setting will be screened for potential eligibility. Identified Members will be authorized consultations with the My Path Palliative Care Provider who will perform an in-person clinical assessment for program eligibility.
   c. Requests by Provider network for My Path consultations will be approved. My Path Palliative Care Providers will perform the consultation and complete a clinical assessment for program eligibility.
2. Eligible Members can decline participation in the program.[9]
3. Members must also have the option to opt-out of the program. If identified with a health status change, the Member may be offered the My Path Palliative Care program again, regardless of the previous opt-out status. An example of a change in health status is hospital admission, discharge or a new diagnosis.[10]

D. **Monitoring and Oversight**

1. IEHP monitors Member access to care through access studies, review of grievances, and other methods. Access to palliative services will comply with regulatory timely access standards.
2. IEHP will monitor palliative care enrollment, network, and utilization data according to the following method:
   a. Enrollment, access, and utilization metrics will be reported on a regular basis with guidance to improve adverse findings per committee direction.
   b. Eligible Members identified through IEHP reports and consultation authorizations will be tracked to ensure access to community-based palliative care is compliant with regulatory standards.
   c. Utilization analysis will include monitoring inpatient admissions and emergency room visits prior to program enrollment as compared to during program enrollment.

[8] National Committee for Quality Assurance (NCQA), ~~2021~~ 2022 Health Plan Standards and Guidelines, PHM 1, Element B, Factor 3
[9] NCQA, ~~2021~~ 2022 HP Standards and Guidelines, PHM 1, Element B, Factor 3
[10] Ibid.

d. Annually, a total cost of care analysis will be performed for Members prior to program enrollment as compared to during program enrollment.

e. Semi-annually or more frequently as needed, IEHP will conduct an onsite chart audit on all contracted My Path Palliative Care Providers to ensure that Quality of Care standards and contractual obligations are met.[11]

f. Audit scope will include but not be limited to:

1) Requirements under the current All Plan Letter;

2) Quality of Care Standards; and

3) Contractual obligations.

g. Scoring categories for the My Path Audit are as follows:

1) Passing 90-100%

2) Non-Compliant <90%

E. **Corrective Action Plan (CAP)**

1. All My Path Palliative Care Providers who score 90% or greater pass the audit. However, all Providers with scores less than 100% may be required to submit a CAP to remedy any identified deficiencies.

a. The My Path Palliative Care Provider must submit a complete and comprehensive CAP response form (See Attachment, "My Path Palliative Care Program CAP Form" in Section 14) to IEHP that adequately addresses all deficiencies.

b. A CAP is considered complete only if all deficiencies are present and submitted together.

2. The CAP must be submitted to IEHP within thirty (30) calendar days of written notification by IEHP of the audit results. The CAP must include the following:

a. The My Path Audit score received;

b. A list of the deficiencies identified by IEHP;

c. CAPs must identify the root cause analysis for the deficiency;

d. CAPs must specifically state how the deficiency is corrected and must include supporting documentation, which may include but not limited to policies and procedures, training agenda, training materials and sign in sheets when applicable;

e. Completion dates for each of the corrective actions;

f. Identification of the person responsible for completing the corrective action; and

g. Follow-up or monitoring plan to ensure that the corrective action plan is successful.

[11] DHCS APL 18-020

3. Upon receipt of the CAP, IEHP reviews the CAP and either approves or denies the CAP in writing within thirty (30) calendar days of receipt.
4. If the CAP is denied:
    a. IEHP will communicate all remaining deficiencies to the My Path Palliative Care Provider with a written request for a second CAP.
    b. My Path Palliative Care Providers requiring a second CAP may be frozen to new authorizations until a CAP is received and approved.
    c. The My Path Palliative Care Provider is required to resubmit a second CAP within fifteen (15) calendar days to IEHP.
5. Upon receipt of the second CAP by IEHP:
    a. If the second CAP is approved, the CAP process is closed. If applicable, the My Path Palliative Care Provider is then re-opened to new authorizations.
    b. If the second CAP is denied, the My Path Palliative Care Provider may be placed in a contract cure process that gives the Provider thirty (30) days to adequately correct the deficiencies.
6. Failure to submit CAPs may result in one of the following activities, depending on the nature of the audit and the seriousness of the deficiency:
    a. Request for cure under contract compliance;
    b. Contract non-renewal; or
    c. Contract termination.

F. **Appeals**

1. My Path Palliative Care Providers wishing to appeal the results of the initial My Path Audit must do so in writing to the IEHP My Path Team at dgmypathteam@iehp.org within thirty (30) calendar days of receiving their results. My Path Palliative Care Providers must cite reasons for their appeal, including disputed items and deficiencies.
2. After receiving a written appeal, the IEHP My Path Team responds to the appealing My Path Palliative Care Provider in writing, noting the status of the appeal. Once an appeal is received, all additional documentation submitted by the My Path Palliative Care Provider is reviewed and, if appropriate, scores may be adjusted. If necessary, a re-assessment audit is performed for areas with scores being appealed.
3. IEHP monitors for subsequent My Path Palliative Care Provider deficiencies through review of grievances, assessment of reports, and results of activities related to each area addressed by the My Path Audits.

~~3.~~

14. UTILIZATION MANAGEMENT

I. My Path Palliative Care Program

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2019
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, ~~2022~~2023

14. UTILIZATION MANAGEMENT

Attachments

DESCRIPTION	POLICY CROSS REFERENCE
Acute Hospital Discharge Need Request Form	14G
Acute Inpatient Data Sheet	14G
Health Plan Referral Form for Out-of-Network and Special Services	14D, 14E, 25E1
Long Term Care (LTC) Follow-up Review Form	14F1, 14F2
Long Term Care (LTC) Initial Review Form	14F1, 14F2
MC 171 Form and Instruction 05-07	14F2
My Path Palliative Care Program CAP Form	14I
PCP Referral Tracking Log	14A1, 14B
Service Request Form from Skilled Nursing Facilities	14F2
Specialty Office Service Auth Sets Grid	14D
Standing Referral / Extended Access Referral to Specialty Care	14A3
UM Timeliness Standards - Medi-Cal	14D, 14E, 14F
Referral Audit CAP Notification Letter	14A1
Referral Audit Corrective Action Plan Tool	14A1

INLAND EMPIRE HEALTH PLAN

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.

Inland Empire Health Plan

Acute Inpatient Data Sheet

(20 Day Stays and Greater)

IPA Name _____ **Date Submitted** _____

Submitted By _____ **Contact Number** _____

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

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

***Legend:**

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

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

This form is for services requiring health plan review.

1. Referrals

DATE: _____

- ❑ **EXPEDITED** - Decision w/in 72 hours
- ❑ **ROUTINE**
- ❑ **PATIENT REQUESTED**
- ❑ **RETRO**
- ❑ **CBAS**
- ❑ **CPO Services**

(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.

FAX COMPLETED REFERRAL FORMS TO (909) 890-5751

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

Inland Empire Health Plan

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:

☐ 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/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

State of California—Health and Human Services Agency

Department of Health Care Services

MEDI-CAL LONG-TERM CARE FACILITY ADMISSION AND DISCHARGE NOTIFICATION

(Instructions and distribution on reverse.)

I. COMPLETE THIS PORTION FOR ALL ACTIONS

Patient's name (last) (first) (MI)	Name of facility
Social security number	Address (number and street)
Note: Level of care is SNF/ICF unless checked here as board and care. ☐	City State ZIP code

II. COMPLETE THIS PORTION ONLY FOR ADMISSIONS

Medi-Cal ID number (taken from the Medi-Cal card)	Admission date (month/day/year)

A. Do you have Medicare Part A, Hospital Coverage?

☐ Yes ☐ No

B. Expected length of stay:

☐ At least one full month after the month of admission

☐ Less than one full month after the month of admission

C. Medi-Cal is expected to pay over 50% of facility cost of care.

☐ Yes, beginning with month of _____, 20__

☐ No, other insurance, private pay, etc.

D. Current income (check all applicable boxes):

☐ Supplemental Security Gold Checks

☐ Social Security Green Checks

☐ Other Income (i.e., railroad, military retirement, etc.)

☐ None

E. Admission from:

☐ Home ☐ Board and Care

☐ Household of another

☐ Acute Hospital—Home, B&C, other household immediately prior to acute

☐ Acute Hospital—SNF/ICF immediately prior to acute

☐ Acute Hospital extended stay—over 30 days

☐ Another SNF/ICF

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

Address (number and street)

City State ZIP code

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

Signature of recipient	Signature of Representative Payee	Phone number

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

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

III. COMPLETE THIS PORTION ONLY FOR DISCHARGES

A. Reason for discharge:

☐ Discharged to Acute Hospital

☐ Discharged to another SNF/ICF

☐ Discharged to residence/home of another

☐ Discharged to Board and Care

☐ Discharged to other

☐ Discharge due to death

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

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

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

Name of facility (if not discharged home)

Address (number and street)

City State ZIP code

Facility representative signature	Date

I. General Instructions

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

II. Admission Instructions

A. Preparation

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

B. Distribution

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

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

Copy 2: Retain for your file.

III. Discharge Instructions

A. Preparation

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

B. Distribution

Original: Send to the Medi-Cal field office.

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

Copy 2: Retain for your file.

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

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

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

Corrective Action Plan (CAP) Form

Original Date Sent to My Path Provider: Click here to enter a date.

Please complete the Root Cause Analysis, Action Plan, Monitoring Plan, and sign and date in the spaces provided below. This CAP is due to IEHP within 30 calendar days of receipt. If you have any questions regarding this CAP, please contact IEHP My Path Team at: dgmypathteam@iehp.org

File Month/ Year	*Type*	*Findings*	**Root Cause Analysis** (to be completed by Provider)	**Action Plan** (to be completed by Provider)	**Monitoring Plan** (to be completed by Provider)	*CAP Accepted (Y/N)*	*Comments*

I understand that I have a responsibility to report any areas where activities are not in place to meet the actions or monitoring noted above, and that an additional audit by the health plan may be undertaken to ensure compliance.

_____ _____

Printed Name of Individual Attesting to CAP Response **Title of Signing Individual**

_____ _____

Signature of Individual Attesting to CAP Response **Date**

Inland Empire Health Plan

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
P.O. Box 1800, Rancho Cucamonga, CA 91729-1800
Fax: (909) 890-5746 Attention: QM Coordinator

Date of Review:

Referral Audit 1st CAP Notification Letter

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
Attention: QM Coordinator
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.

Inland Empire Health Plan

SPECIALTY OFFICE SERVICE AUTHORIZATION SETS

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

Procedure	CPT Code
Allergy - Skin Testing for 80 or Fewer Tests	95004 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

Procedure	**CPT Code**
GYN – Abnormal Pap Follow-Ups *and:*	99213-99215 (X 3)
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

Inland Empire Health Plan

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

Type of Request	Decision	Notification Timeframes
Urgent Pre-Service Requests ***Definition****: Member's condition is such that 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 when the non-urgent timeframe for making a determination would be detrimental to the Member's life or health, or could jeopardize Member's ability to regain maximum function.*[1]	• Determine within forty-eight (48) hours of receiving the request if the request does not meet the definition for urgent pre-service request. • If accepted as an urgent pre-service request, render a decision in a timely fashion appropriate for the nature of the Member's condition, not to exceed 72 hours after receipt of the information reasonably necessary and requested by the plan to make the determination.[2,3] The initial 72-hour authorization timeframe may be extended by up to 14 additional days if the Member requests an extension, or if IEHP or the Delegate can justify its need for additional information and demonstrate how the extension is in the Member's interest.	• If the request does not meet the definition for urgent pre-service request, notify the requesting Provider via fax within forty-eight (48) hours of receiving the request (including holidays and weekends). • If accepted as an urgent pre-service request: ✓ The Requesting Provider must be initially notified of the decision by phone or fax within 24 hours of the decision.[4] ✓ The Member and Requesting Provider must be notified of the decision in writing within72 hours of receipt of request.[5] • For terminations, suspension, or reductions of previously authorized services, notify the Member at least ten (10) days prior to the date of the action.[6]
Urgent Concurrent Requests (Example: Continued Home Health, Physical Therapy, Speech Therapy, and Occupational Therapy requests, only when initial pre-service request for service did not expire) ***Definition****: Member's condition is such that the Member faces an imminent and serious*	• Determine within forty-eight (48) hours of receiving the request the request does not meet the definition for urgent concurrent request. • If accepted as an urgent concurrent request, render a decision in a timely fashion appropriate for the nature of the Member's condition, not to exceed 72 hours after receipt of the information reasonably necessary and requested by the plan to make the determination.[8,9]	• If the request does not meet the definition for urgent concurrent request, notify the requesting Provider via fax within forty-eight (48) hours of receiving the request (including holidays and weekends). • If accepted as an urgent concurrent request: ✓ The Requesting Provider must be initially notified of the decision by phone or fax within 24 hours of the decision.[10]

[1] California Health and Safety Code (Health & Saf. Code) § 1367.01(h)(2)
[2] Ibid.
[3] Department of Health Care Services (DHCS)-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization
[4] CA Health & Saf. Code § 1367.01(h)(3) & (4)
[5] CA Health & Saf. Code § 1367.01(h)(3)
[6] 42 CFR § 438.404(c)(1)
[7] CA Health & Saf. Code § 1367.01(h)(3)
[8] CA Health & Saf. Code § 1367.01(h)(2)
[9] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization
[10] CA Health & Saf. Code §1367.01(h)(3) & (4)

Utilization Management Timeliness Standards

Type of Request	Decision	Notification Timeframes
threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or when the non-urgent timeframe for making a determination would be detrimental to the Member's life or health, or could jeopardize Member's ability to regain maximum function.[7]	The initial 72-hour authorization timeframe may be extended by up to 14 additional days if the Member requests an extension, or if IEHP or the Delegate can justify its need for additional information and demonstrate how the extension is in the Member's interest.	✓ The Member and Requesting Provider must be notified of the decision in writing within 72 hours of receipt of request.[11] • For terminations, suspension, or reductions of previously authorized services, notify the Member at least ten (10) days prior to the date of the action.[12]
Standard (Non-Urgent) Pre-Service Requests	Render a decision in a timely fashion appropriate for the nature of the Member's condition, but no longer than five (5) business days from receipt of the information reasonably necessary and requested to make the determination, not to exceed 14 calendar days following receipt of the request for service.[13,14] The initial 14 calendar day authorization timeframe may be extended by up to 14 additional days if the Member or the Provider requests an extension, or if IEHP or the Delegate can justify its need for additional information and demonstrate how the extension is in the Member's interest.	• The Requesting Provider must be initially notified of the decision by phone or fax within 24 hours of the decision.[15] • The Member and Requesting Provider must be notified of the decision in writing within two (2) business days of the decision using the appropriate NOA template.[16] • For terminations, suspension, or reductions of previously authorized services, notify the Member at least ten (10) days prior to the date of the action.[17]
Standard (Non-Urgent) Concurrent Requests)	Render a decision in a timely fashion appropriate for the nature of the Member's condition, but no longer than five (5) business days from receipt of the information reasonably necessary and	• The Requesting Provider must be initially notified of the decision by phone or fax within 24 hours of the decision.[20]

[11] CA Health & Saf. Code §1367.01(h)(3) & (4)
[12] 42 CFR § 438.404(c)(1)
[13] CA Health & Saf. Code § 1367.01(h)(1)
[14] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization
[15] CA Health & Saf. Code § 1367.01(h)(3) & (4)
[16] CA Health & Saf. Code § 1367.01(h)(3)
[17] 42 CFR § 438.404(c)(1)

Utilization Management Timeliness Standards

Type of Request	Decision	Notification Timeframes
	requested to make the determination, not to exceed 14 calendar days following receipt of the requested service.[18,19] The initial 14 calendar day authorization timeframe may be extended by up to 14 additional days if the Member or the Provider requests an extension, or if IEHP or the Delegate can justify its need for additional information and demonstrate how the extension is in the Member's interest.	• The Member and Requesting Provider must be notified of the decision in writing within two (2) business days of the decision using the appropriate NOA template.[21] • For terminations, suspension, or reductions of previously authorized services, notify the Member at least ten (10) days prior to the date of the action.[22]
Post-Service/ Retrospective Review	Render a decision within thirty (30) calendar days of receiving the information that is reasonably necessary to make the retrospective authorization determination.[23,24,25,26]	• The Member and Requesting Provider must be notified of the decision in writing within thirty (30) calendar days of receiving the information that is reasonably necessary to make the retrospective authorization determination.[27,28,29]

[18] CA Health & Saf. Code § 1367.01(h)(1)
[19] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization
[20] CA Health & Saf. Code §1367.01(h)(3) & (4)
[21] CA Health & Saf. Code § 1367.01(h)(3)
[22] 42 CFR § 438.404(c)(1)
[23] CA Health & Saf. Code § 1367.01(h)(1)
[24] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization
[25] National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, UM 5, Element A, Factor 5
[26] NCQA, 2022 HP Standards and Guidelines, UM 5, Element B, Factor 5
[27] CA Health & Saf. Code § 1367.01(h)(1)
[28] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization
[29] NCQA, 2022 HP Standards and Guidelines, UM 5, Element B, Factor