7. COORDINATION OF CARE

A. Care Management Requirements

1. PCP Role

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

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

PROCEDURES:

A. PCPs are responsible for coordinating care management services for assigned Members, when indicated.

B. PCPs are responsible for identifying Members who may potentially require care management services and notifying the Behavioral Health & Care Management (BH&CM) Department. PCPs may also submit a completed CM Referral Form to IEHP to refer the Member for care management. This form is found in the "Providers" portal of the IEHP website (www.iehp.org) (see Attachment, "IEHP Care Management Referral Form" found on the IEHP website).[1] Members, who may benefit from care management include, but are not limited to:

   1. Members with complex medical or behavioral health conditions requiring multiple Providers or multiple interventions and care coordination needs;
   2. Members with suspected or confirmed developmental disabilities that may qualify for enrollment into Inland Regional Center/Early Start Program;
   3. Potential major organ transplant candidates;
   4. Members frequently accessing Emergency Room services;
   5. Members who live alone, are frail, have inadequate family support systems, and may need continuity of care services; and
   6. Any other Member who could benefit from Care Management services.

C. PCPs are responsible for referring Members to IEHP for health education classes, care management programs, and disease management programs.

D. PCPs are responsible for coordinating care for the Member with the IEHP Care Manager, including but not limited to contacting other clinicians or entities, facilitating the transfer of medical records as necessary and initiating specialty referrals.

[1] https://www.iehp.org/en/providers/provider-resources?target=forms

7. COORDINATION OF CARE

A. Care Management Requirements

1. PCP Role

E. PCPs are responsible for ensuring Members receive preventive care in accordance with IEHP's approved guidelines.

F. PCPs are responsible for referring Members to the appropriate Long-Term Care (LTC) services when it is determined that the Member is a potential candidate. See Policy, 9E1 "Long-Term Care-Skilled Level" for more information.

G. PCPs are expected to participate in the development of the Member's Individualized Care Plan (ICP)and in Interdisciplinary Care Team (ICT) case conferences, as needed.

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07. COORDINATION OF CARE

A. Care Management Requirements
2. Continuity of Care

APPLIES TO:

A. This policy applies to IEHP Covered Members

POLICY:

A. IEHP may provide coverage for continued care from a non-contracted provider or completion of services from a terminated provider, subject to cost share and any benefit limitations.

PROCEDURES:

Continuity of Care from a Non-Contracted Provider

A. Requests for continuity of care must be requested within 60 days of the Member's effective date unless there is documentation that indicates that it was not reasonably possible to request within the 60-day timeframe. The non- contracted provider must be willing to accept the same contract terms applicable to providers contracted with IEHP and who practice in the same or similar geographic region.

Completion of Services from a Terminated Provider

A. IEHP may provide coverage for completion of services from a provider whose contract has been terminated, subject to cost share and any other benefit limitations. The provider must be willing to accept the same contract terms applicable to the provider prior to the contract termination. Request for continued care with a terminated provider must be requested within 30 days of the provider's date of termination, unless there is documentation that it was not reasonably possible to make the request within this time.

B. If IEHP's contract with a Physician or other provider is terminated, IEHP will transfer any affected Members to another Network Physician or provider and make every effort to ensure continuity of care.

C. Members who are in a course of treatment from a terminated provider and meet any of the conditions below can request continuity of care.

1. An acute condition;
2. A serious chronic condition within 12 months from the Member's effective date under this plan;
3. A pregnancy (including the duration of the pregnancy and immediate postpartum care);
4. Maternal mental health, not to exceed 12 months from the diagnosis or from the end of the pregnancy, whichever occurs later;

5. A newborn up to 36 months of age not to exceed twelve months from your effective date with IEHP;
6. A terminal illness (for the duration of the terminal illness); or
7. A surgery or other procedure that has been authorized by IEHP Covered California as part of a documented course of treatment.

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7. COORDINATION OF CARE

B. Early Start Services and Referrals

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. Primary Care Providers (PCPs) and Specialists are responsible for assessing children's developmental status and identifying children who may be eligible for receiving Early Start services during Well Child exams, or at other medical encounters as appropriate.[1] This includes children with a condition known to lead to developmental delay, those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay.

B. PCPs and IPAs are responsible for providing primary care and/or arranging all medically necessary diagnostic, specialty, and/or or therapeutic services to evaluate, correct and/or ameliorate a suspected or confirmed condition.

DEFINITION:

A. Early Start Program – California's early intervention program for infants and toddlers with disabilities and their families.

PROCEDURES:

Early Start Program

A. Members from birth to 36 months of age may be eligible for early intervention services if, through documented evaluation and assessment, they meet one (1) of the criteria listed below:[2,3]

   1. Has a developmental delay of at least 25% in one (1) or more areas of cognitive, receptive communication, expressive communication, social or emotional, adaptive, or physical and motor development including vision and hearing;

   2. Has an established risk condition of known etiology, with a high probability of resulting in delayed development, including fetal alcohol syndrome; and

   3. Is considered at high risk of having a substantial developmental disability due to a combination of biomedical risk factors of which are diagnosed by qualified personnel.

B. Based on the child's assessed need(s) and in collaboration with the family, the Early Start Program develops the child's Individualized Family Service Plan (IFSP).[4] Services may include:[5]

   1. Assistive technology devices and assistive technology services;

[1] Title 17 California Code of Regulations (CCR), § 52040
[2] California Government Code (Gov. Code), § 95014(a)
[3] 17 CCR § 52022
[4] 17 CCR § 52104
[5] Title 20 United States Code (U.S.C) § 1432

2. Audiology;
3. Family training, counseling and home visits;
4. Health services;
5. Medical services for diagnostic/evaluation purposes only;
6. Nursing services;
7. Nutrition services;
8. Occupational therapy;
9. Physical therapy;
10. Psychological services;
11. Service coordination (Case Management);
12. Social work services;
13. Special instruction;
14. Speech and language services;
15. Transportation and related costs; or
16. Vision services.

For more information about services offered through Early Start Program, refer to the following website: https://www.dds.ca.gov/services/Early-Start/.

C. Newly referred families whose infants or toddlers are "at risk" for developmental delay or disability will receive the following services through the Early Start Family Resource Network (ESFRN) (additional details are available on their website at http://www.esfrn.org):

1. Information;
2. Resources;
3. Referrals; and
4. Targeted outreach.

Identification and Referral of Members

A. All Members from birth to 36 months of age, suspected of having a developmental concern, including those at risk for developmental delay, are referred to the Early Start program to determine eligibility for services.[6] Early Start will facilitate each family's access to local Family Resource Center's Prevention Resource and Referral Services with parental consent.

B. The Provider must perform the following to facilitate the referral to the Early Start Program, including first discussing their concerns with the family:

[6] CA Gov. Code, § 95014(a)

1. Regular well baby examinations according to the Child Health and Disability Program (CHDP) schedule (with specific findings noted);
2. Diagnostic and laboratory and radiological test results;
3. Routine developmental assessment using standardized developmental tools;
4. Evaluation of hearing and vision;
5. Explain developmental concerns to family;
6. Identify established risk conditions of known etiology, with a high probability of resulting in delayed development;
7. Obtain parental consent to send child's medical records to the Early Start Program;
8. Other medical referrals as appropriate;
9. Make referral as soon as possible to the Early Start Program;
10. Inform family of the Early Start referral and the importance of following up on child's development; and
11. Inform IEHP that the Member was referred to the Early Start Program.

C. Anyone can make a referral, including parents, medical care Providers, neighbors, family members, foster parents, and daycare providers. The referral must be made by phone or by completing the online referral form: inlandrc.org/intake

Riverside County	**San Bernardino County**
Phone: (909) 890-4763	(909) 890-4711

D. The Early Start Program determines a child's eligibility and assessment of service needs.[7]

Primary Care and Specialty Referrals

A. PCPs are responsible for referring Members with suspected or confirmed developmental delay for all medically necessary specialty diagnostic and/or treatment services including but not limited to the following. See Policy 09D, "Pre-Service Referral Authorization Process," for more information.

1. Specialty diagnostic services to evaluate the Member's condition (e.g., computed tomography (CT) or magnetic resonance imaging (MRI) scans, etc.);
2. Specialists for diagnosis or treatment (e.g., Neurologists);
3. Referrals to Psychologists or Psychiatrists as needed;
4. Referral to other types of Providers as needed (e.g., Physical Therapy (PT), Occupational Therapy (OT)); and

[7] "Parents' Rights: An Early Start Guide for Families", https://www.dds.ca.gov/wp-content/uploads/2019/02/EarlyStart_ProceduralSafeEng_20190205.pdf

5. All other specialty health care services as needed.

IEHP Responsibilities

A. IEHP is responsible for coordinating all medically necessary specialty care including:

1. In-network diagnostic, therapeutic or specialty services;
2. Out-of-network services as needed; and

B. When a Member is receiving services from the Early Start Program, IEHP is responsible for ensuring that medical and health assessment information is provided to the Early Start Program, as needed. IEHP is responsible for arranging all necessary transfer of medical information includes but is not limited to:

1. Facilitating PCP or specialist telephonic communication with the Early Start Program or Local Education Agency (LEA) staff as needed;
2. Transferring medical records, diagnostic test results or other hard copy medical information as needed; and
3. Arranging case conferences with PCP, Specialist and Early Start Program or LEA staff as needed.

For more information about services offered by the Regional Center, refer to the following website: https://www.dds.ca.gov/RC/.

C. Member rosters indicating Early Start eligibility are updated monthly on the secure IEHP Provider portal.

D. IEHP Behavioral Health & Care Management (BH & CM) Department is responsible for the following functions:

1. Facilitating working relationships with Regional Center as needed;
2. Assisting with referrals to the Early Start Program, care coordination or care management as needed;
3. Resolving any disputes between the Regional Center, PCP/Specialists
4. Attend Regional Center meetings, as necessary;
5. Arranging appropriate training for PCP staff regarding the Early Start Program; and
6. Other assistance as required.

7. COORDINATION OF CARE

B. Early Start Services and Referrals

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C. Genetically Handicapped Persons Program

APPLIES TO:

A. This policy applies to IEHP Covered Members.

POLICY:

A. The Genetically Handicapped Persons Program (GHPP) is a health care program which provides medical care and other related services for persons with genetically handicapping conditions.[1] GHPP will cover services only if they are not covered by IEHP. The program applies to members with specific GHPP eligible conditions.

B. GHPP helps each client achieve the highest level of health and functioning through:[2]

1. Early identification and enrollment into the GHPP for persons with eligible conditions.
2. Prevention and treatment services from highly skilled Special Care Center teams.
3. Ongoing care in the home community provided by qualified physicians and other health team members.

PROCEDURES:

GHPP Services

A. GHPP services Members with specific genetic diseases. Conditions may include but are not limited to the following:[3]

1. Cystic fibrosis;[4]
2. Diseases of the Blood, i.e., Hemophilia, Von Willebrand's Disease, Sickle Cell Disease;[5]
3. Diseases of the Brain and Nerves, i.e., Huntington's disease, Hereditary Spastic Paraplegia;[6]
4. Diseases of Metabolism, i.e., Phenylketonuria (PKU), Wilson's Disease, Galactosemia;[7] and
5. Von Hippel-Lindau Disease.

For the most current overview of GHPP medical eligibility information, refer to the following website at: http://www.dhcs.ca.gov/services/ghpp/Pages/MedicalEligibility.aspx

[1] Title 17 California Code of Regulations (CCR) § 2930
[2] Ibid.
[3] California Health and Safety Code (Health & Saf. Code) § 125130
[4] 17 CCR § 2932
[5] Ibid.
[6] Ibid.
[7] Ibid.

B. GHPP offers the following program components:[8]

1. Medical and dental services provided in inpatient and outpatient settings including surgical and reconstructive services, home health, medications, vitamins, food supplements, blood products and oxygen;
2. Physical, occupational and speech therapy;
3. Prosthetic and orthopedic appliances and other durable medical equipment; and
4. Psychosocial services and respite care.

C. GHPP provides services at approved Special Care Centers (SCC). The GHPP Special Care Centers are a system that:[9]

1. Provides coordinated care to clients with specific genetic conditions;
2. Multi-disciplinary and multi-specialty teams which consists of doctors, nurses, social workers, and other health team members;
3. Provides family centered planning; and
4. Facilitates timely and appropriate care.

D. The GHPP SCCs are located throughout California and usually connected with tertiary level medical centers. Each SCC must comply with the GHPP program standards to become an approved provider.

Identification and Referral of GHPP Cases

A. Primary Care Providers (PCPs), and Specialists are responsible for the identification of Members with potentially eligible conditions and subsequent referral of those Members to the GHPP.

B. Once approved, GHPP provides authorization and payment for medical and non-medical services to Members with conditions eligible for treatment under the GHPP guidelines.

C. Application and all supporting documentation may be submitted to GHPP in one of the three (3) following ways (see Attachment, "GHPP Application to Determine Eligibility" found on the IEHP website)[10]:

Email: GHPPEligibility@dhcs.ca.gov;
Fax: 916-440-5762; or
Mail: Genetically Handicapped Persons Program
Integrated Systems of Care Division
MS 4502
P.O. Box 997413

[8] https://www.dhcs.ca.gov/services/ghpp/Pages/Benefits.aspx.
[9] Ibid.
[10] https://www.iehp.org/en/providers/provider-resources?target=forms

Sacramento, CA 95899-7413

D. IEHP Members may apply for GHPP benefits. Once the Member is enrolled in the program, they will receive the same services they are receiving from IEHP in addition to the services available through the GHPP, such as Special Care Center services.

Provider Responsibilities

A. GHPP is only responsible for treatment and payment for GHPP eligible conditions that are not a covered by IEHP. PCPs and IEHP continue to provide for all other medically necessary care without interruption while pending GHPP determination. Financial and authorization responsibilities are delineated in the Division of Financial Responsibility (DOFR).

B. The PCP must follow all GHPP referred cases throughout the treatment process and assist with coordination and continuity of care, including but not limited to facilitating referrals and tracking outcomes

C. IEHP is available to assist Providers with care coordination activities through the following methods:

1. Identification of appropriate community referral sources available to Members; or
2. Facilitating GHPP referrals if assistance is needed.

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D. Organ Transplant

APPLIES TO:

A. This policy applies to all IEHP Covered Members and their living donors.

POLICY:

A. IEHP covers all medically necessary adult and pediatric major organ transplants (MOTs) for eligible beneficiaries. IEHP will authorize, refer, and coordinate, the delivery of the MOT benefit and all medically necessary services associated with MOTs, including, but not limited to, organ procurement costs, cadaver organ transplants, hospitalization, surgery, discharge planning, readmissions from complications, post-operative services, dialysis, medications not otherwise covered by the MCP contract, , and care coordination, including care for living donors. These services will be provided at approved Network transplant facilities.

1. Bone Marrow;
2. Heart;
3. Heart/Lung combined;
4. Combined Liver and Kidney
5. Liver /Intestinal;
6. Kidney;
7. Liver;
8. Intestinal;
9. Small Bowel;
10. Combined Liver and Small Bowel;
11. Lung;
12. Simultaneous Kidney and Pancreas;
13. Pancreas; and
14. Stem Cell.

B. IEHP covers medically necessary kidney, corneal, and autologous islet cell transplants from facilities that have been approved by Centers for Medicare and Medicaid Services (CMS) for these types of transplants.

PROCEDURES:

Provider Responsibilities

A. The Primary Care Provider (PCP) or Specialist is responsible for the initial diagnostic work-up prior to a referral to an approved Network transplant facility. During the initial diagnostic work-up, all prior authorizations for needed procedures or referrals to specialists, second

surgical opinions, or hospital admissions must follow IEHP's prior authorization referral procedures.

IEHP Responsibilities

A. IEHP is responsible for the authorization and care of all medically necessary MOTs per the Division of Financial Responsibility (DOFR).

1. IEHP is responsible for coordinating pre-work up, transplant surgery, and post-transplant care for all MOTs. This includes related care including but not limited to, dialysis, evaluation of potential donors, organ procurement, readmissions due to complications, living donor care[1], and transportation services. For more information about the transportation process, see Policy 4C, "Non-Emergency Medical and Non-Medical Transportation Services."
2. IEHP is responsible for assisting the PCP or Specialist with all necessary diagnostic, therapeutic, or other specialty referrals for the Member being evaluated as a candidate for a possible organ transplant.
3. IEHP refers Members who meet medical necessity criteria for a specific major organ transplant to the appropriate transplant facility:
    a. Members 21 years old and older are referred to an approved Network transplant facility for an evaluation within 72 hours of the PCP or Specialist identifying the Member as a potential candidate for the MOT.
4. If the Member is deemed a suitable candidate by the appropriate facility, the facility will place the Member on the transplant waiting list.
5. Once a Member has been determined to be an appropriate surgical candidate for the organ transplant, the facility will submit a request for authorization of transplant surgery.
    a. IEHP uses nationally recognized clinical criteria and/or IEHP UM Subcommittee-Approved Authorization Guidelines, when making decisions related to major organ transplants. Please see Policy 9a, "Utilization Management - Delegation and Monitoring" for a description of decision process.
    b. Decisions for these referrals are made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Providers (see "UM Timeliness Standards – Covered California" found on the IEHP website[2]).

B. Under circumstances in which the transplant program cannot perform the MOT surgery and an organ is available, IEHP may arrange for the surgery to be performed at an out-of-network hospital.

[1] California Health and Safety Code (Health & Saf. Code), §1300.67.005
[2] https://www.iehp.org/en/providers/provider-resources?target=forms

7. COORDINATION OF CARE

D. Organ Transplant

C. Please see Policy 6A, "Pharmacy Benefits and Services," for information on prescription drug coverage for major organ transplants.

D. IEHP coordinates all aspects of the referral, including providing to the approved Network transplant facility all medical information (diagnostic tests, specialty physician notes, etc.) relevant to the particular major organ transplant; and assuring that the Member makes all appointments.

E. IEHP ensure coordination of care between all providers, organ donor entities, and transplant programs, for both the donor and the recipient, to ensure the MOT is completed as expeditiously as possible.

F. IEHP is responsible for the oversight and monitoring of its MOT network. If IEHP becomes aware that a contracted transplant program is no longer active, or has lost its approved Network transplant facility status, IEHP will notify impacted Members no later than 30 days prior to the planned inactivation date. IEHP will coordinate the redirection of care and services.

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E. Complex Case Management

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. IEHP, in collaboration with the Member's Primary Care Provider (PCP), provides complex case management (CCM) services, which include:

1. Basic case management services;
2. Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
3. Intense coordination of resources to ensure Member regains optional health or improved functionality; and
4. With the Member and their PCP's input, development of care plans specific to individual needs, and updating these care plans at least annually.
5. Members may opt-in or opt-out of the CCM program.

B. PCPs provide basic care management services and are responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining continuity of care.[1]

PURPOSE:

A. To ensure the coordination of care and services for the high and rising risk Members with complex conditions and help them access needed resources.

DEFINITION:

A. Complex Case Management – The systematic coordination and assessment of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

PROCEDURES:

A. IEHP does not delegate CCM responsibilities. PCPs and other Specialists may instead, refer Members that may benefit from CCM services, including information that supports the complex need to IEHP's Behavioral Health and Care Management (BH & CM) Department. The CM Referral Form can be found on the IEHP website at www.iehp.org or on the secure IEHP Provider portal.

[1] California Welfare and Institutions Code (Welf. &Inst. Code), § 1300.45

7. COORDINATION OF CARE

E. Complex Case Management

Member Identification

A. Identification of Members for CCM include data and referral sources, which identify health risk factors, complex social needs, and behavioral health concerns.

B. Members needing CCM services typically have (a) health condition(s) status that is severe in nature and without intensive assistance the Member would likely decline or use acute services more frequently. Members needing CCM level of assistance often require numerous or extensive resource coordination to improve their health or circumstances. The following CCM Program Trigger List was developed as a general guide for identifying Members that may benefit from CCM and should be used in combination with considering the following questions:

1. Does the Member have two (2) or more chronic medical conditions not being managed, along with social determinant concerns such as food insecurity, financial concerns, housing, or other factors that may affect the Member's decisions/health status?
2. Is the Member's condition expected to progress in complexity and/or result in hospitalizations/ER visit (s) without resources and specialists?
3. Does the Member have one or more complex behavioral health conditions not being managed effectively and would need multiple resources/specialists?

Triggers for CCM include but are not limited to:

Diagnosis Triggers

1. Advanced Liver Disease
2. Metastatic Cancer
3. Pediatric Cancer
4. Decompensating Neurological Conditions
5. New Cerebral Vascular Accident
6. Trauma (current)
7. Chronic uncontrolled (physical condition and/or behavioral health symptoms) that impact Member's activities of daily living (ADL)
8. Chronic homelessness impairing the ability to function in the community

AND/OR

Utilization Triggers

1. Six (6) or more ER visits in the past 6 months
2. Four (4) or more inpatient stays for physical or behavioral health (self-reported) in the past 12 months

3. On six (6) or more medications to treat chronic conditions and/or polypharmacy for the same medical/behavioral health conditions
4. Projected cost of care within a twelve (12)-month period anticipated to be > $100,000 (including high cost medications and/or DME)

AND/OR

Psychosocial/Frailty Triggers

1. Weight loss of more than eight (8) pounds per month or 48 pounds in six months
2. Severe vision impairment needing total dependence to complete ADLs
3. Prescence of Decubitus Ulcer (2 or more at Stage III; 1 at Stage IV)

Member Referrals

A. IEHP will review referrals to its CCM program daily. Complex Case Managers are responsible for reviewing cases and evaluating Members who do meet CCM criteria. Complex Case Managers will continue routine outreach to Members and assess for care coordination and case management needs.

Monitoring and Oversight

A. While IEHP does not delegate CCM, IEHP will review cases that potentially qualify and assess for appropriate referral.

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F. Dental Services

APPLIES TO:

A. This policy applies to IEHP Covered Members.

POLICY:

A. Primary Care Providers (PCPs) are required to perform dental screenings and oral health assessments for all Members as part of the initial health assessment (IHA) and periodic health examinations.[1] Please see Policies 10A, "Initial Health Assessment," 10B, "Adult Preventive Services" and 10C1, "Pediatric Preventive Services – Well Child Visits" for more information.

B. Dental services may be provided to Medi-Cal Members on a fee-for-service (FFS) basis through Denti-Cal.[2] IEHP provides covered medical services related to dental services that are not provided by dentists or dental anesthetists, including prescription drugs, laboratory services, physical examinations required for admission for a dental procedure.[3,4]

PROCEDURES:

A. IEHP provides medically necessary federally required dental services including fluoride varnish for adults that may be performed by a medical professional.[5] Please see Policy 10C1, "Pediatric Preventive Services – Well Child Visits" for information on dental services for pediatric Members.

B. IEHP is responsible for the facility component and services related to dental procedures that require intravenous sedation and general anesthesia that are provided by a physician anesthesiologist or certified registered nurse anesthetist for Medi-Cal Members who need dental services performed by a licensed dentist that are reasonable and necessary for the prevention, diagnosis, and treatment of dental disease, injury or defect. A dental procedure may be provided under general anesthesia in a setting deemed appropriate.[6]

C. Adult Denti-Cal services are available to Members age 21 and above. Dental services are covered under Medi-Cal FFS for Members under age 21 and for pregnant women per Denti-Cal specific allowable procedure codes.[7]

D. PCPs refer Medi-Cal Members needing dental services to Denti-Cal Practitioners by giving

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27) Exhibit A, Attachment 11, Provision 15, Dental
[2] DHCS All Plan Letter (APL) 15-012 (Revised) Supersedes Policy Letter (PL) 13-002, "Dental Services – Intravenous Sedation and General Anesthesia Coverage"
[3] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27) Exhibit A, Attachment 11, Provision 15, Dental
[4] DHCS APL 15-012
[5] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27) Exhibit A, Attachment 11, Provision 15, Dental
[6] Ibid.
[7] Ibid.

the Member the Denti-Cal Practitioner referral phone number, (800) 322-6384.[8] PCPs can also refer Medi-Cal Members needing dental services to IEHP Member Services at (800) 440-IEHP (4347) for assistance in accessing the Denti-Cal Practitioner referral line.

E. PCPs and IPAs continue to provide all necessary health care services to Members even if referred to a dental Practitioner for services.

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[8] California Department of Health Care Services, Medi-Cal Dental Member Contact Information, https://www.dental.dhcs.ca.gov/Contact_Us/Medi-Cal_Dental_Member_Contact_Information/

7. COORDINATION OF CARE

G. Behavioral Health - Behavioral Health Services

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. IEHP covers benefits for Members with behavioral health conditions, as well as those with or at risk for substance use and addictive disorders. IEHP focuses on engaging and providing access to those needing services.

DEFINITIONS:

A. Mental Health and Substance Use Disorders (SUD)- Refer to a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.[1]

   1. Changes in terminology, organization, or classification of mental health and substance use disorders (SUD) in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.[2]

B. "Medically Necessary" or "medical necessity" when it reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

PROCEDURES:

Covered Benefits

A. IEHP provides access to the following medically necessary services, when provided by network PCPs, Specialists, or other licensed mental health professionals within their scope of practice. Please see Policy 09D, "Pre-Service Referral Authorization Process" for more information.

B. Prior authorization is not required, and Members may self-refer for the following services to a contracted IEHP provider. All other services require prior authorization:

   1. Emergency Room Services;

[1] California Welfare and Institutions Code (Welf.& Inst. Code), §1374.72
[2] Ibid.

2. Individual Therapy;
3. Group Therapy;
4. Outpatient Medical Management;
5. Opioid Replacement Therapy;
6. Outpatient Mental Health and Substance Use Care;
7. Crisis Intervention; and
8. Behavioral Health Treatment including Applied Behavioral Analysis (ABA) for members with Autism, is a covered benefit (See Policy 07G1, "Behavioral Health Treatment" for more information).

C. IEHP does not deny or disallow reimbursement for clinically appropriate and covered mental health services even when:

1. Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether access criteria is met;
2. Services are not included in an individual treatment plan; or
3. The Member has a co-occurring mental health condition and SUD.

Identification/Diagnosis

A. PCPs and other health care Providers are responsible for identifying Members with behavioral health conditions that require referral to behavioral health specialists for treatment and triage according to the level of urgency. Identification of these Members can occur during routine visits.

B. PCPs and BH Providers are responsible for diagnosing and treating Members' behavioral health conditions within their scope of practice.

C. PCPs and other Providers can call into IEHP should they have any questions:

1. **IEHP Behavioral Health & Care Management Department:**
   Monday-Friday 8:00am-5:00pm
   Provider Line: (909) 890-2054
   Member Line: (800) 440-4347
   Fax Number: (909) 890-5763

Treatment

A. Certain behavioral health conditions beyond the PCP's scope of practice require treatment by a BH Provider. In these cases, the PCP can directly refer the Member to a BH Provider for an initial assessment without prior authorization.[3]

[3] 28 CCR § 1300.74.72(f)

Referral Process

A. IEHP processes all requests for BH or SUD services in compliance with State and Federal regulatory requirements, including requirements for parity in mental health and substance use disorder benefits.[4,5]

B. IEHP's Behavioral Health and Care Management (BH & CM) Department can assist in the referral process for all Members. Members may be directed to IEHP BH & CM Department through several sources, which include, but are not limited to:

1. Member or their representative;
2. PCPs and other Providers;
3. IPAs; and
4. IEHP Departments.

C. IEHP will process requests for BH services. Determinations are made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Providers. See Policy 09D, "Pre-Service Referral Authorization Process" for more information.

1. Expedited/Urgent Referrals

   a. If a Member presents with a life-threatening psychiatric emergency or behavioral health crisis (e.g., Member is a danger to self or others, is making threats of violence) the Provider must follow their own emergency protocol (e.g., call 911). Please see Policies 09C, "Emergency Services" and 04A, "Access Standards" for more information.

   b. Assistance with locating a hospital emergency department is available after hours through the Nurse Advice Line at (888) 244-4347.

Care Management

A. PCPs and BH Providers are responsible for maintaining communication with treating Providers, assigned IPAs and/or IEHP BH & CM Department to coordinate the Member's care.

B. IEHP retains responsibility for performing all BH care coordination activities related to Behavioral Health Providers. The medical management system is utilized to track and trend Members currently requiring care management as well as those with catastrophic or potentially high-risk BH conditions and to ensure appropriate follow-up and intervention.

C. The case management team works with complex cases to ensure Members are connected to resources. See policy CCA 07E, "Complex Case Management" for more details.

[4] 42 CFR § 438.910(d)
[5] CA Health & Saf. Code § 1367.01

Releasing Member Information

A. IEHP Providers must release medical information and behavioral health or substance use treatment records upon request by the IEHP for coordination of care, when IEHP is the payer of services. Refer to Policy 3B, "Information Disclosure and Confidentiality of Medical Records."

B. Providers may use their own Release of Information (ROI) form or use IEHP's Authorization for Use or Disclosure of Patient Health Information Form.

Reporting and BH Web Forms

A. PCPs and BH Providers utilize the secure IEHP Provider portal and BH web forms to submit requests and review reports.

B. PCPs must inform IEHP of Members with a positive screen for SUD, Depression, Anxiety, and/or Psychosis to a BH provider and alert IEHP.

C. BH Providers must submit the "request for continued services through the secure IEHP Provider portal as follows:

1. Prior to the expiration date of the authorization, request continued services, when medically necessary;
2. When a Member no longer needs medically necessary services, the Member discharges from treatment, and/or when treatment is terminated for any reason; and
3. Provide results of a second opinion three (3) business days after the second opinion was performed. Please see Policy 09B, "Second Opinions" for more information.

E. All IPAs, PCPs and BH Providers can access the necessary web forms on the secure IEHP Provider portal. Providers can receive training on how to use the secure IEHP Provider portal or how to complete the BH web forms by calling the IEHP Provider Call Center at (909) 890-2054 or emailing providerservices@iehp.org.

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07. COORDINATION OF CARE

G. Behavioral Health

1. Behavioral Health Treatment

APPLIES TO:

A. This policy applies to IEHP Covered Members.

POLICY:

A. IEHP provides all medically necessary Behavioral Health Treatment (BHT) services for eligible Members. This applies to Members diagnosed with autism spectrum disorder (ASD) or Pervasive Developmental Disorder and Members for whom a licensed physician, surgeon, or psychologist determines that BHT services are medically necessary.[1]

PURPOSE:

A. To ensure benefits and services are provided in a standardized manner to Members in accordance with State health care regulations.

DEFINITIONS:

A. Behavioral Health Treatment (BHT) – These services include applied behavioral analysis and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. The goal is to promote, to the maximum extent practicable, the functioning of a beneficiary.[2]

B. Applied Behavioral Analysis (ABA) – The process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior.

PROCEDURES:

BHT Coverage

A. The Member must have a current authorization before BHT services can be provided. A Member must:

   1. Be diagnosed with Autism Spectrum Disorder (ASD); and

   2. Have a recommendation from a licensed physician, surgeon or psychologist that evidence-based BHT services are medically necessary.

B. BHT is provided, observed, and directed under an approved BHT plan developed by (a) BHT Provider(s), which includes ABA and other evidence-based methodologies.

C. IEHP will offer Members continuity of care from an out-of-network provider of BHT services

[1] California Welfare and Institutions Code (Welf. & Inst. Code), §1374.73
[2] Ibid.

for up to twelve (12) months if required conditions are met. Please see Policy 07A2, "Care Management Requirements – Continuity of Care" for more information.

BHT Treatment Plan

A. The approved BHT treatment plan must also meet the following criteria:[3]

1. Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence based BHT services;
2. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors;
3. Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation;
4. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives;
5. Include the Member's current level of need (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan of generalization and report goal as met, not met, modified (include explanation);
6. Utilize evidence based BHT services with demonstrated clinical efficacy tailored to the Member;
7. Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the Member's progress is measured and reported, transition plan, crisis plan, and each individual Provider responsible for delivering the services;
8. Include care coordination involving the parents or caregiver(s), school, state disability programs and institutions, as applicable;
9. Consider the Member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision;
10. Deliver BHT services in a home or community-based setting, including clinics. Any portion of medically necessary BHT services that are provided in school must be

[3] CA Welf. & Inst. Code), §1374.73

clinically indicated as well as proportioned to the total BHT services received at home and community; and

11. Include an exit plan/criteria; and
12. The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the health care service plan upon request.

B. The BHT provider must review, revise, and/or modify no less than once every six months the BHT treatment plan.

C. IEHP permits the Member's Guardian(s) to be involved in the development, revision, and modification of the BHT treatment plan to promote Guardian participation in treatment.

BHT Provider Responsibilities

A. BHT Providers must adhere to the following access standards for BHT:

1. Appointment for initial assessment must be offered within ten (10) business days of authorization being approved.
    a. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

B. BHT Provider must promptly notify IEHP, in writing, if at any time BHT Provider determines that BHT Provider no longer satisfies the requirements of applicable laws and/or regulations.

BHT Services

A. All BHT services provided by the BHT Provider under this policy require prior authorization. See policy 07G, "Behavioral Health – Behavioral Health Services" for more information.

B. BHT Providers can submit an amendment for additional treatment hours. This may be needed when school is out of session or there is an increase in maladaptive behaviors, etc. The BHT Provider must include the clinical justification for the increase in hours. The plan will review and approve as medically necessary. Submit the request via the Coordination of Care Treatment Plan form found on the Provider Portal.

C. Every six (6) months, BHT Providers must submit to IEHP progress reports using the template provided in this manual (see Attachment, "6 Months and Exit Progress Report Template"

found in the IEHP website[4]).

D. The BHT Provider should work collaboratively with other health care professionals involved in the care of a Member (e.g., PCP, Community Entities, Local Education Agencies, Regional Centers, Occupational Therapy, Speech Language Pathologist, Mental Health Provider).

E. Exit criteria may be met when the Member has met the goals and objectives identified in the assessment plan or the treatment goals and objectives are no longer appropriate, and BHT is no longer medically necessary. Other exit criteria may include, but are not limited to the following:

1. Parents have a poor or conflicting relationship or alliance with the BHT Provider, the Member qualifies for a higher or lower level of care, and/or lack of improvement on goals, or failure to meet intervention goals. This may also be the case when other services are deemed more appropriate such as Speech Therapy or Occupational Therapy.
2. Members can also meet exit criteria when their goals are met.

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[4] https://www.iehp.org/en/providers/provider-resources?target=forms

7. COORDINATION OF CARE

H. Vision Services

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. Vision services, including a comprehensive eye exam, lenses and frames for Covered California Members are provided directly by IEHP per the Covered California Vision benefit.

B. Optometry services for Covered California Members include Diabetic Retinal Examination (DRE) Therapeutic Pharmaceutical Agents (TPA), diagnostic, ancillary and supplemental procedures used for the evaluation of the visual system. Vision Providers are required to obtain prior authorizations for all routine vision benefits.

PROCEDURES:

Initial Health Assessment – Vision Screening

A. The initial health assessment for children and adults must be performed by the Primary Care Provider (PCP) within sixty (60) days of enrollment for Covered California Members under the age of 18 months and within one hundred twenty (120) days of enrollment for Members 18 months and older. A component of the initial health assessment requires vision screening of the eyes to determine the presence of eye disease or potential refractive errors. The PCP must advise the Member of findings and encourage the Member to seek vision services when appropriate. Refer to Policy 5A, "Initial Health Assessment" for more information.

Follow-up Vision Screening

A. The PCP must continue to observe Members for vision conditions and advise Members to seek vision services as applicable. Follow-up screenings for children, periodic vision screenings should be performed in accordance with IEHP Well Child Visit requirements as outlined in Policy 10C1, "Pediatric Preventive Services – Well Child Visits."

Access to Vision Providers

A. PCPs are responsible for directing Members to an IEHP Vision Provider if non-medical vision conditions are noted during the visits or if the Member has Diabetes and is being referred for a Diabetic Retinal Exam (DRE).

B. Vision Providers can obtain prior authorization through IEHP's Vision Referral Request online at www.iehp.org or through the Provider Call Center (PCC) at (844) 248-4347

Vision Providers for Covered California Members

A. A Vision Provider list is included in the IEHP Provider Directory or can be obtained online at www.iehp.org. To receive assistance with referral, a Vision Provider may call IEHP Provider Call Center (PCC) at (844) 248-4347 Members may also call IEHP Member Services at (855) 433-4347to obtain assistance.

Vision Benefits for Covered California Members

A. Members are limited to one bilateral comprehensive eye examination with refraction, including dilation when medically indicated, in a twenty-four (24) month period unless more frequent examinations are determined to be medically necessary.

1. All routine vision benefits require prior authorizations.
2. Providers are strongly encouraged to obtain self-service referrals through **IEHP's Vision Referral Request** online on the Provider Portal at www.iehp.org or through the Provider Call Center (PCC) at (844) 248-4347
3. Before ordering services, Providers must verify eligibility through IEHP's Online Eligibility Verification System at www.iehp.org. When ordering medically necessary absorptive lenses, medical justification must be provided and prior authorization must be obtained. IEHP designated contract optical lab order forms are available online at www.iehp.org.
4. Eyeglass frames are covered for all Covered California Members. Eyeglass frames provided to Members must be of good quality with the manufacturer's or American distributor's name or identification clearly stamped on the frame. Only frames that Providers supply to the general public may be given to Members. Discontinued or closeout frames are not covered and cannot be dispensed. The Provider must maintain an adequate supply of covered frames to allow sufficient choice by the Member (i.e., male/female and ten (10) choices for children).
5. Providers must use the following IEHP designated contracted optical laboratories when ordering lens materials. IEHP Providers must use the IEHP Lab Order Form (See Attachment, "IEHP Lab Order Form" found on the IEHP website1) when ordering materials from the IEHP designated contract lab. Express Lens Lab

17150 Newhope St., Suite 305

Fountain Valley, CA 92708-4251

(714) 545-1024 Phone

(714) 556-2026 Fax

Unique Optical

43990 Golf Center Pkwy Ste B2

Indio, CA 92203

(760) 391-9100Phone

(760) 391-9101 Fax

B. Pediatric and Adult Members diagnosed with diabetes are entitled to an annual Diabetic Retinal Examination (DRE). Vision Providers are required to coordinate care with Member's PCP by notifying the PCP in writing of the results of the DRE.

1. Prior to rendering services, Providers are required to obtain a referral through IEHP's Vision Referral Request online at www.iehp.org or through the Provider Call Center (PCC) at (844) 248-4347
2. For the purpose of benefit availability, annual shall mean once per calendar year but no less than nine (9) months since the last DRE.
3. DRE may be performed on the same day as a comprehensive examination if the Member is eligible for the periodic routine eye examination.
4. Vision Providers are required to coordinate care with the Member's PCP by notifying the Member's PCP in writing of the results of the DRE, utilizing the IEHP PCP Vision Report Form (See, "PCP Vision Report Form" found on the IEHP website[1]).

C. Members are limited to low vision aids once per Calendar Year.[2]

1. A physician or optometrist must prescribe vision aids when medically necessary, after appropriate assessment.

D. The IEHP Therapeutic Pharmaceutical Agents (TPA) Program allows IEHP credentialed and TPA certified Providers to perform specific services to Members without a referral from the Members' PCPs. IEHP follows Covered California guidelines for referral requirements.

1. Any IEHP Vision Provider may provide TPA services to Pediatric Members if the following minimum criteria are met:
   a. Provider is an ophthalmologist that participates in IEHPs vision program.
   b. Provider is credentialed by IEHP.
   c. Optometrists must be TPA, TPL, TPG or TLG certified as verified by the California Board of Optometry.
   d. Provider must be contracted by IEHP to provide those services.
   e. Symptoms and conditions covered under the Program are consistent with Section 3041 of the Business and Professions Code and Section 3051.76 of the Title 5 California Code of Regulations.[3,4]
   f. All Members with confirmed chronic conditions must be referred to their PCP unless Vision Provider has TPG and/or TLG certification to treat glaucoma.

[1] Ibid.
[2] Title 22 California Code of Regulations (CCR) §51317
[3] California Business and Professions Code (Bus. & Prof. Code) §3041
[4] Title 5 California Code of Regulation (CCR) §3051.75

2. Additional equipment that is required in order to provide TPA services includes:
   a. Binocular Indirect Ophthalmoscope.
   b. Condensing Lens.
   c. Automated Threshold Field Analyzer.
   d. Goldman Applanation Tonometer.
3. Prior to rendering services, Providers are required to obtain a referral in accordance to Covered California guidelines through IEHP's Vision Referral Request online at www.iehp.org or through the Provider Call Center (PCC) at (844) 248-4347
4. TPA services may not be performed on the same day as a comprehensive examination or Diabetic Retinal Examination (DRE).
5. TPA Providers are required to notify the Member's PCP that medical services have been provided within two (2) working days of rendering services. Providers must complete the PCP Vision Report form (See, "PCP Vision Report Form" found on the IEHP website[5])..
6. A legible copy of the PCP Vision Report must be sent to the Member's assigned PCP.
   a. The Member's assigned PCP information can be found on the eligibility page of the secure Provider portal.
7. The PCP Vision Report form must be completed in its entirety and includes:
   a. Patient's presenting symptoms.
   b. Diagnosis description.
   c. ICD code(s).
   d. Procedure(s) and/or treatment performed.
   e. If applicable, the name and type (form) of medication prescribed.
   f. Provider's signature.
   g. Date of the next follow-up appointment, if indicated, in "Next Visit" otherwise specify N/A (not applicable).
8. Claims for TPA, TPG and TLG services can be submitted through **IEHP's Claims Entry** form on the IEHP Provider portal at www.iehp.org on a CMS 1500 Health Insurance Claim Form and must include all information necessary to process the claim for payment.
   a. Under the TPA Program, IEHP performs retrospective review on all non-authorized services. Claims are also reviewed for unbundling and inappropriate use of codes. Claims with unbundled services, or where two (2) or more lower level codes are

[5] https://www.iehp.org/en/providers/provider-resources?target=forms

billed on the same date of service without substantiated documentation, result in lower reimbursement.

b. Members cannot be billed for any covered service, including services that have been denied because of improper billing.

9. Prescription Medications

a. All prescription medications prescribed to IEHP Members must comply to IEHP's formulary. Providers wishing to prescribe non-formulary medication must first submit a Prescription Drug Prior Authorization (RxPA) Request form for approval.

b. TPA Providers must use Prescription Drug RxPA Request forms for the following:

1) Medication or dosage not included in the IEHP formulary.

2) Code 1 medications used for treatment of conditions or criteria other than those specified by their restrictions.

3) Branded medications when generic is available.

4) Prescriptions for formulary medications that do not comply with Dose/Duration/or Quantity guidelines as outlined in the IEHP formulary at www.iehp.org under Pharmaceutical Services page.

5) The RxPA form is available on the IEHP web portal at https://ww3.iehp.org/en/providers/pharmaceutical-services/pharmacy-rx-pa-universal-form/.

c. A Member currently taking medication that has been deleted from IEHP's formulary may continue to receive the medication, if prescribed.

d. All completed Prescription Drug RxPA Requests will be reviewed within twenty-four (24) hours for approval or denial.

E. IEHP PCPs continue to provide all necessary health care services to Members even if the Member has been referred to a Vision Provider for services.

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7. COORDINATION OF CARE

H. Vision Services

1. Vision Provider Referrals

APPLIES TO:

A. This policy applies to all IEHP Covered Pediatric Members.

POLICY:

A. IEHP Vision Providers are required to provide evaluation and management (E&M) services within their scope of practice to Members with known or suspected diseases and conditions of the eye and visual system. [1]

B. Vision Providers caring for Covered California Members that require further diagnosis and treatment beyond the scope of practice of the Vision Provider must refer the Member to the appropriate health care Provider, as follows:

1. IEHP Covered Members with a known or suspected pathology of the eye, or any of its appendages, may be referred directly by the Vision Provider to an Ophthalmologist by submitting a referral request to the Member's assigned IPA or IEHP, as applicable.
2. IEHP Covered Members with a known or suspected medical condition that may be systemic or neurological in nature shall be referred to the Member's Primary Care Provider (PCP) for appropriate coordination of care.
3. Vision Providers may also call the IEHP Provider Call Center (PCC) at (844) 248-4347 for assistance regarding information on the Member's IPA or IEHP contact assignment for referral submission.

PROCEDURES:

Identification/Diagnosis

A. Vision Providers are responsible for identifying Members with any pathological ocular health condition that requires treatment. Identification of these Members can occur during the routine physical examination of the eyes and visual system and through review of the past medical history or review of systems, or during any visit for acute or chronic conditions.

B. Members presenting with complex or mixed symptoms or conditions that make the diagnosis uncertain or that may indicate a systemic etiology must be referred to the Member's PCP for assessment, diagnosis, and/or treatment. If the Vision Provider determines that an ophthalmologist consultation and/or treatment is warranted, the Vision Provider can submit a referral directly to the Member's assigned IPA or IEHP, as applicable.

D. Vision Providers are responsible for treating Members with ocular conditions within their scope of practice. Treatment includes the provision of appropriate optical devices and the use

[1] California Business and Professions Code (Bus. & Prof. Code) § 3041

of topical ophthalmic pharmaceutical agents, as indicated. Typical ocular health conditions within the scope of practice of Vision Providers, depending on their level of certification and legal authority include, but are not limited to:

1. Refractive and motility disorders of the human eyes
2. Ocular infections
3. Ocular inflammations and allergies
4. Ocular trauma and superficial foreign bodies
5. Primary open angle glaucoma
6. Nothing in this section shall be construed to grant privileges to the optometric Vision Provider beyond the scope set forth in the statutes and regulations of the Optometry Code.[2,3]

E. Scope and limitations to IEHP Covered California Vision Benefit: IEHP Covered California Pediatric Members are entitled to a routine comprehensive eye examination every twelve (12) months and, if medically indicated. Eyeglass frames and lenses are covered for Pediatric Members every twelve (12) months. When indicated, medical evaluation and management services of certain eye conditions are available to the Member through an IEHP Vision Provider. Treatment of any eye condition shall be limited to acute conditions. The long-term treatment of chronic medical conditions of the eyes shall be managed and coordinated by the Member's PCP.

Referral to PCP

A. Vision Providers shall complete a PCP Vision Report (See Attachment, "PCP Vision Report Form" found on the IEHP website[4]) to report examination findings and/or treatment provided during an active ocular condition that require further evaluation or follow up by Member's PCP.

1. To ensure Member's continuity of care, Vision Providers are required to notify the Member's PCP if medical services have been provided within two (2) days of rendering service.

Referral to Ophthalmologist

A. Vision Providers, with the assistance of the IPA Utilization Management (UM) staff, are responsible for referring Covered California Members to the appropriate ophthalmologist specialty Provider for assessment, diagnosis and treatment as needed.

[2] CA Bus. & Prof. Code § 3041
[3] California Code of Regulations (CCR) § 1569
[4] https://www.iehp.org/en/providers/provider-resources?target=forms

B. PCPs are also responsible for referring Members to the appropriate ophthalmologist specialty Provider for assessment, diagnosis and treatment as needed.

C. PCPs are responsible for direct coordination of the clinical care of the Member in concert with the ophthalmologist specialty Provider through phone calls, transfer of medical records, and other specialty referrals as indicated.

D. Vision Providers shall prepare a written request for referral on the standardized Ophthalmologist Referral Request Form at www.iehp.org (See Attachment, "Ophthalmologist Referral Form" found on the IEHP website[5]) and submit the completed referral to the Member's assigned the IPA within twenty-four (24) hours of the encounter with the Member. Direct Vision Providers can submit a Referral Request Form via the Secure Provider Portal in lieu of a written request. Vision Providers may indicate desired ophthalmological sub-specialty by selecting: General Ophthalmology, Retinal Specialist or Pediatric Ophthalmology.

E. IPA UM staff are responsible for faxing back a copy of the completed referral form including the specific ophthalmologist selected back to the Vision Provider.

F. Vision Providers may also call the IEHP PCC at (844) 248-4347 and/or Medical Director for advice or consultation regarding Member ocular health issues, including diagnostic or treatment consultation, or the appropriateness of a referral.

Medications

A. IEHP covers medically necessary medications for the treatment of ocular disease as listed in the IEHP formulary.

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[5] https://www.iehp.org/en/providers/provider-resources?target=forms

7. COORDINATION OF CARE

I. Developmental Disabilities

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. IEHP has established procedures for the identification, referral and case management of Members identified with or suspected of having developmental disabilities to ensure their access to medically necessary screening, preventive, diagnostic, and treatment services.

PROCEDURES:

Identification and Referral of Developmental Disability Cases

A. Members at risk for developmental disabilities may be identified through:
    1. Primary Care Provider (PCP) or Specialist referrals; or
    2. IEHP Care Manager through:
        a. Screening of incoming California Children's Services (CCS) referrals;
        b. Review of hospital admission and discharge information;
        c. Member calls;
        d. IEHP Inland Regional Center (Regional Center) liaison; and
        e. IEHP Specialty Kids Intervention Team.

B. To qualify for Regional Center services, the Member's developmental disability must originate before their 18th birthday, be expected to continue indefinitely, and constitute a substantial disability.[1]

Provider Responsibilities

A. PCPs are required to provide all necessary primary care for individuals with developmental disabilities including:
    1. Well-child exams;
    2. Immunizations;
    3. Developmental status screening, illness or injury care;
    4. Diagnostic testing (laboratory, x-rays) as needed;
    5. Health education as needed; and
    6. Other primary care services as needed.

[1] California Welfare and Institutions Code (Welf. & Inst. Code), § 4512

B. PCPs are required to arrange for and/or request from IEHP all medically necessary specialty, diagnostic or therapeutic services, including out-of-network referrals, if a service is not available in-network. If services are out-of-network, PCP must send the referral to IEHP's UM Department for authorization. See Policy 09D, "Pre-Service Referral Authorization Process," for more information. These services include but are not limited to:

1. Referral to Specialist or sub-specialist Providers (e.g., Neurologists, Physiatrists);
2. Referrals for occupational or physical therapy;
3. Orders for medically necessary Durable Medical Equipment (DME) or home health services; and
4. Referrals for specialized diagnostic testing (e.g., computed tomography (CT) or Magnetic resonance imaging (MRI)).

C. IEHP is responsible for referring to the Regional Center, Members in need of non-medical, home and community-based services such as:

1. Training in skills for daily living;
    a. Acquisition of skills and behavior and/or;
    b. Family support; and/or
    c. Day habilitation.
2. For all ages:
    a. Respite care; and/or
    b. Assisted living.

D. PCPs are responsible for assessing the behavioral health status of Members and referring Members with behavioral health disorders outside their scope of practice to IEHP for additional services. Refer to Policy 07G, "Behavioral Health - Behavioral Health Services," for more information.

E. PCPs or Obstetrics (OB) Providers who identify Members as being at risk of parenting a child with genetic disorders must provide counseling and referrals, as appropriate. Please see Policy 05D1, "Obstetric Services – Guidelines for Obstetrical Services" for more information.

F. PCPs and Specialists are responsible for referring to the Regional Center Members under the age of 18 who may be potentially eligible for Home and Community-Based Services for the Developmentally Disabled (HCBS-DD) Waiver Program.

G. PCPs are responsible for assisting the family with referrals to the Regional Center's intake coordinator. The family must contact the Regional Center to initiate the intake process. For referral of children age 0 to 36 months, see Policy 07B, "Early Start Services and Referrals." Referrals include the following information:

1. The reason for referral;

2. The complete medical history and physical examination, including appropriate developmental screens;
3. The results of developmental assessment/psychological evaluation and other diagnostic tests as indicated.

H. Regional Center staff review the referral and notify the PCP and the Member, and Member's family or guardian when appropriate, regarding the Member's eligibility and recommendations for services.

Care Management

A. IEHP coordinates services with Regional Center to achieve optimum outcomes for Members with developmental disabilities. IEHP's Regional Center liaison and Specialty Kids Intervention Team assist as needed.

B. IEHP is responsible for performing the following activities:

1. Assisting the PCP with the referral to the Regional Center including arranging for transfer of medical information, approving medically necessary referrals and contact with the Regional Center;
2. Consulting with the PCP in the development of the individual care plan (ICP) for the Member; and
3. Coordinating necessary follow-up between the PCP, Specialty Providers, IEHP, and the Regional Center to assure an organized care plan and delivery for the Member.

C. IEHP remains responsible for providing care coordination and care management services for Members regardless of whether they receive services from Regional Center.

D. IEHP is responsible for providing assistance to the Regional Center in complex or difficult cases or when differences arise regarding necessary services or care plans.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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