09. UTILIZATION MANAGEMENT

A. Delegation and Monitoring

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. IEHP and its Delegates shall develop, implement, and continuously update and improve a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of medically necessary covered services.

B. IEHP maintains responsibility of ensuring that its Delegates comply with all applicable State and Federal laws and other requirements set forth by the Department of Managed Health Care (DMHC), and IEHP.

PURPOSE:

A. To ensure a well-structured UM program and to make utilization decisions affecting the health care of Members in a fair, impartial and consistent manner.

DEFINITION:

A. Delegate – A medical group, health plan, individual or entity contracted with IEHP to provide administrative services or health care services for a IEHP Covered eligible Member.

PROCEDURES:

UM Program Requirements

A. Delegates must have a UM Program Description that includes, at minimum, the following information:[1]

   1. Mission statement, goals, and objectives;
   2. Program structure, which includes at minimum:
      a. UM staff's assigned activities;
      b. UM staff who have the authority to deny coverage;
      c. Involvement of a designated physician;
      d. The process for evaluating, approving and revising the UM Program, and the staff responsible for each step;

[1] NCQA, 2024 HP Standards and Guidelines, UM 1, Element A

e. The UM Program's role in the Quality Improvement (QI) program, including how the organization collects UM information and uses it for QI activities; and

f. The organization's process for handling appeals and making appeal determinations;

3. Senior-level physician involvement, including their responsibilities in setting UM policies, supervising program operations, reviewing UM cases, participating on the UM committee, and evaluating the overall effectiveness of the UM program;

4. Processes and information sources used to make determinations, which includes but is not limited to:

a. UM functions, the services covered by each function or protocol and the criteria used to determine medical necessity;

b. How medical necessity and benefits coverage for inpatient and outpatient services are determined and guide the UM decision-making process; and

c. The description of the data and information the Delegate uses to make determinations; and

5. Other UM program requirements.

B. Delegates must, on at least an annual basis, evaluate their UM program to ensure that this remains current and appropriate. Delegates must update their UM program based on this program evaluation, which must include but not be limited to the review of the following:[2]

1. UM program structure;

2. Program scope, processes, information sources used to determine benefit coverage and medical necessity;

3. The level of involvement of the senior-level physician in the UM program; and

4. Member and Provider experience data.

C. Delegates must have the following UM structure in place:

1. Delegates must have a designated senior-level physician who holds an unrestricted license in the state of California, responsible for the following. Please see Policy 18N, "IPA Medical Director Standards" for more information: [3]

a. Ensuring the process by which the Delegate reviews and approves, partially approves (modifies) or denies, based in whole or in part on medical necessity, requests by Providers prior to, retrospectively, or concurrent with the provision of health care services to Members comply with State, federal and contractual requirements;[4,5]

[2] NCQA, 2024 HP Standards and Guidelines, UM 1, Element B
[3] NCQA, 2024 HP Standards and Guidelines, UM 1, Element A, Factor 1
[4] California Health and Safety Code (Health & Saf. Code) §1367.01
[5] NCQA, 2024 HP Standards and Guidelines, UM 4, Element A, Factor 1

b. Ensuring that medical decisions are rendered by qualified medical personnel and are not influenced by fiscal or administrative management considerations; [6,]

c. Participation in staff training;[7]

d. Monitoring documentation for adequacy;[8]

e. Be available to UM staff on site or by telephone;[9]

f. Signing off on all internal policies and procedures related to UM; and

g. Chairing the UM Committee or designating a Chair.

Delegates shall communicate to the IEHP Senior Medical Director any changes in the status of their UM Medical Director.

2. **UM Committee -** Delegates must establish a UM Committee that directs the continuous monitoring of all aspects of UM, including the development of appropriate standards administered to Members, with oversight by the Medical Director.[10] For more information on a UM Committee's functions, structure, membership, and other requirements, please see Policy 2G, "Utilization Management Subcommittee."

3. **Use of Appropriate Professionals for UM Decisions:** To ensure that first-line UM decisions are made by individuals who have the knowledge and skills to evaluate working diagnoses and proposed treatment plans, IEHP requires its Delegates to adopt the following standards for personnel making review decisions and reviewing denials. The following types of personnel can perform the functions listed, as delegated to do so: [11]

a. UM Technicians/Coordinators – eligibility determination, editing of referral form for completeness, interface with Provider offices to obtain any needed non-medical information.[12]Delegates should be able to provide a list of all services approvable by UM Technicians/Coordinators.

b. Licensed Vocational Nurses (LVN) – initial review of medical information, initial determination of benefit coverage, concurrent inpatient, obtaining additional medical information, as needed, from the Provider's offices,[13] and approval of referrals based on IEHP-approved authorization criteria, and initiate denials for non-covered benefits.

c. Registered Nurses (RN) – initial review of medical information, initial determination of benefit coverage, obtaining additional medical information as needed, from the

[6] Title 22, California Code of Regulations (CCR) § 53857
[7] NCQA, 2024 HP Standards and Guidelines, UM 4, Element A, Factor 1
[8] Ibid.
[9] Ibid.
[10] NCQA, 2024 HP Standards and Guidelines, UM 1, Element A, Factor 3
[11] NCQA, 2024 HP Standards and Guidelines, UM 4, Element A, Factor 2
[12] NCQA, 2024 HP Standards and Guidelines, UM 6, Element A
[13] Ibid.

Provider's office,[14] approval of referrals based on medical necessity or IEHP-approved authorization criteria, and providing medical necessity recommendation to the physician reviewer.

d. Physician-Reviewer - A designated physician with unrestricted license in the state of California must review all denials and partial approvals (modifications) based in whole or in part on medical necessity and obtain additional medical information from the treating physician as needed.[15, 16,17,18]

4. **Use of Board-Certified Physicians for UM Decisions:** Delegates must have written policy and procedure demonstrating their use of designated physicians with current unrestricted license for UM decisions.[19]
   a. When a case review falls outside the clinical scope of the reviewer, or when medical decision criteria do not sufficiently address the case under review, a Board-certified physician in the appropriate specialty must be consulted prior to rendering a decision.
   b. Delegates must either maintain a list of Specialists to be utilized for UM decisions or consult with an organization contracted to perform such review. The interaction may be completed by a telephone call to a network Specialist, a written request for review, or use of a contracted vendor that provides Board Specialist review.
   c. The physician reviewer determines the type of specialty required for consultation.

Clinical Criteria for UM Decisions

A. Delegates must apply nationally recognized clinical criteria and/or IEHP UM Subcommittee-Approved Authorization Guidelines, when determining the medical appropriateness of health care services.[20] Criteria sets approved by IEHP include Title 22 of the California Code of Regulations, Apollo Managed Care Guidelines/Medical Review Criteria, Milliman Care Guidelines, World Professional Association for Transgender Health standards of care (WPATH), National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium, IBM Watson Health Products: Micromedex, UpToDate, DMHC All Plan Letters (APLs), Early Childhood Service Intensity Instrument (ESCII), developed by American Academy of Child and Adolescent Psychiatry, Child and Adolescent Level of Care Utilization System (CALOCUS) 20, developed by the American Association of Community Psychiatry (AACP), Level of Care Utilization System (LOCUS) 20, developed by the American Association of Community Psychiatry (AACP), and for substance use disorders (SUD) of Members at any age, IEHP uses the American Society of Addiction Medicine

[14] NCQA, 2024 HP Standards and Guidelines, UM 6, Element A
[15] CA Health & Saf. Code § 1367.01(e)
[16] NCQA, 2024 HP Standards and Guidelines, UM 4, Element A, Factor 1
[17] NCQA, 2024 HP Standards and Guidelines, UM 4, Element C
[18] NCQA, 2024 HP Standards and Guidelines, UM 6, Element A
[19] NCQA, 2024 HP Standards and Guidelines, UM 4, Element F, Factors 1 and 2
[20] NCQA, 2024 HP Standards and Guidelines, UM 2, Element A

(ASAM) 3rd Edition 2013.[21,22] IEHP may distribute additional criteria following approval by the IEHP UM Subcommittee.

1. **Development:** Criteria or guidelines that are developed by IEHP and used to determine whether to authorize, partially approve (modify), or deny health care services are developed with involvement from actively practicing health care Practitioners.[23] IEHP ensures these criteria or guidelines are consistent with sound clinical principles and processes and are evaluated at least annually and updated if necessary.[24, 25]
2. **Application:** Delegates must apply criteria in a consistent and appropriate manner based on available medical information and the needs of individual Members. The application of criteria takes into consideration individual factors such as age, co-morbidities, complications, progress of treatment, psychosocial situation, previous claims history, home environment, and all submitted clinical documentation.[26] Additionally, criteria applied takes into consideration whether services are available within the service area, benefit coverage, and other factors that may impact the ability to implement an individual Member's treatment plan. The organization also considers characteristics of the local delivery system available for specific Members, such as: [27]

    a. Availability of services, including but not limited to skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the Member after hospital discharge;

    b. Coverage of benefits for skilled nursing facilities, subacute care facilities, home care where needed, or Behavioral Health; and

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

    Once eligibility and benefit coverage has been established, IEHP and its Delegates must ensure consistent application of UM criteria by following this specific order: [28]

    For Medical Services:

    a. Federal and State Laws, Title 22 of California Code of Regulations (CCR), or DMHC All Plan Letters; **then**

[21] CA Health & Saf. Code § 1363.5(b)
[22] NCQA, 2024 HP Standards and Guidelines, UM 2, Element A, Factor 1
[23] NCQA, 2024 HP Standards and Guidelines, UM 2, Element A, Factor 4
[24] CA Health & Saf. Code §1363.5
[25] NCQA, 2024 HP Standards and Guidelines, UM 2, Element A, Factor 5
[26] NCQA, 2024 HP Standards and Guidelines, UM 2, Element A, Factor 2
[27] NCQA, 2024 HP Standards and Guidelines, UM 2, Element A, Factor 3
[28] NCQA, 2024 HP Standards and Guidelines, UM 2, Element A, Factor 1

b. World Professional Association for Transgender Health standards of care (WPATH), National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium **or** IBM Watson Health Products: Micromedex; **then**

c. MCG Health Informed Care Strategies Care Guidelines; **then**

d. Apollo Medical Review Criteria Guidelines for Managing Care; **then**

e. Up To Date.

For Behavioral Health Services:

a. Federal and State Laws, Title 22 of the California Code of Regulations (CCR) or DMHC All Plan Letters;

b. World Professional Association for Transgender Health standards of care (WPATH), for mental health (MH) disorders of Members ages 0 through 5, IEHP uses the Early Childhood Service Intensity Instrument (ESCII), developed by American Academy of Child and Adolescent Psychiatry, for mental health (MH) disorders of Members ages 6 through 17, IEHP uses the Child and Adolescent Level of Care Utilization System (CALOCUS) 20, developed by the American Association of Community Psychiatry (AACP), for mental health (MH) disorders of Members ages 18 and older, IEHP uses Level of Care Utilization System (LOCUS) 20, developed by the American Association of Community Psychiatry (AACP), for substance use disorders (SUD) of Members at any age, IEHP uses the American Society of Addiction Medicine (ASAM) 3rd Edition 2013.

3. **Annual Review and Adoption of Criteria**: IEHP develops and/or presents criteria to the IEHP UM Subcommittee for adoption and implementation. IEHP may develop and recommend criteria for review and approval by the IEHP UM Subcommittee. After approval by UM Subcommittee, the criteria are sent to the IEHP Quality Management (QM) Committee for reference and disseminated to Providers via letter, website or email. Members of the IEHP UM Subcommittee and Practitioners in the appropriate specialty, review clinical criteria annually and update, as necessary.[29]

4. **Process for Obtaining Criteria**: Delegates must disclose to Providers, Members, Member's representatives, or the public, upon request, the clinical guidelines or criteria used for determining health care services specific to the procedure or condition requested.[30,31]

   Delegates may distribute the guidelines and any revision through the following methods:

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

[29] NCQA, 2024 HP Standards and Guidelines, UM 2, Element A, Factor 5
[30] CA Health & Saf. Code §1363.5
[31] NCQA, 2024 HP Standards and Guidelines, UM 2, Element B, Factors 1 and 2

b. On its website if it notifies Providers that information is available online.

The Covered California (CCA) Notice of Action (NOA) must state the address and phone number to call for obtaining the utilization criteria or benefits provision used in the decision.[32] Every disclosure must be accompanied by the following statement: "The materials provided to you are guidelines used by the plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your Health Plan" (See "Response to Request for UM Criteria" found on the IEHP website[33]).[34] Delegates must maintain a log of all requests for criteria (See "Request for UM Criteria Log" found on the IEHP website[35]).

5. **Annual Assessment of Consistency of UM Decisions (Inter-rater Reliability):** Delegates are responsible for evaluating, at least annually, the consistency with which health care professionals involved in utilization review apply appropriate criteria for decision-making.[36] must act on identified opportunities to improve consistency.[37] The sample assessed must be statistically valid, or Delegates may use one (1) of the following three (3) auditing methods: [38]

   a. Five percent (5%) or fifty (50) of its UM determination files, whichever is less;

   b. NCQA's 8/30 methodology; or

   c. Ten (10) hypothetical cases.

UM Authorization Process Requirements

A. Delegates must have written policies and procedures regarding the process to review, approve, partially approve (modify) or deny prospective, concurrent or retrospective requests by Providers concerning provision of health care services for Members. These policies and procedures must be available to the public upon request.[39]

   1. **Specialty Referral Systems:** Delegates must maintain a specialty referral system to track and monitor referrals requiring prior authorization. The system shall include approved, partially approved (modified), and denied referrals received from both contracted and non-contracted providers, as well as the timeliness of these referrals.

[32] NCQA, 2024 HP Standards and Guidelines, UM 7, Element B, Factor 3
[33] https://www.iehp.org/en/providers/provider-resources?target=forms
[34] CA Health & Saf. Code §1363.5
[35] https://www.iehp.org/en/providers/provider-resources?target=forms
[36] NCQA, 2024 HP Standards and Guidelines, UM 2, Element C, Factor 1
[37] NCQA, 2024 HP Standards and Guidelines, UM 2, Element C, Factor 2
[38] NCQA, 2024 HP Standards and Guidelines, UM 2, Element C, Factor 1
[39] CA Health & Saf. Code § 1367.01(b)

2. **System Controls:** Delegates must have and be able to demonstrate system controls to protect data specific to denial and appeal notifications and receipt dates from being altered outside of prescribed protocols.[40]
3. **Out-of-Network Services:** Authorization and notification of decision for proposed services, referrals, or hospitalizations involves utilizing information such as medical records, test reports, specialist consults, and verbal communication with the requesting Provider. Part of this review process is to determine if the service requested is available in network. If the service is not available in network, arrangements are made for the Member to obtain the service from an out of-network provider for this episode of care.[41]
4. **Prior Authorization Requirements:** IEHP must maintain a list of services that require prior authorization or a list of services that do not require prior authorization like below, at minimum.
    a. The prior authorization process described in this policy do not apply to these services, which do not require prior authorization:
        1) Emergency services and services necessary to treat and stabilize an emergency medical condition (See Policy 9C, "Emergency Services"); [42]
        2) Family planning (See Policy 5F, "Family Planning Services");
        3) Abortion services (See Policy 4E, "Access to Services with Special Arrangements");
        4) Sexually Transmitted Infection (STI) services (See Policy 5G, "Sexually Transmitted Infection (STI) Services");
        5) Sensitive and confidential services (See Policy 4E, "Access to Services with Special Arrangements");
        6) HIV testing and counseling (See Policy 10I, HIV Testing and Counseling");
        7) Immunizations (See Policies 5B, Adult Preventive Services" and 5C2, "Pediatric Preventive Services – Immunization Services");
        8) Routine OB/GYN services, including prenatal care by Family Care Practitioner (credentialed for obstetrics) within the IPA's network;[43]
        9) Biomarker testing for advanced or metastatic stage 3 or 4 cancers;[44]

[40] NCQA, 2024 HP Standards and Guidelines, UM 12, Element A
[41] NCQA, 2024 HP Standards and Guidelines, MED 1, Element D
[42] NCQA, 2024 HP Standards and Guidelines, MED 9, Element C, Factors 1 through 3
[43] NCQA, 2024 HP Standards and Guidelines, MED 1, Element A
[44] California Health and Safety Code (CA HSC) §1367.665

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.[45]

10) Urgent Care;

11) Preventive services;[46] and

12) The following mental health and substance use disorder (SUD) services:

a) Emergency room services;

b) Individual therapy;

c) Group therapy;

d) Diagnostic evaluation;

e) Outpatient medication management;

f) Opioid replacement therapy;

g) Outpatient mental health and substance use care; and

h) Crisis intervention.

b. Upon receipt of a request for prior authorization of a preventive service, Delegates must utilize the DHCS-approved Member letter "Prior Authorization Not Required" to inform the Member and Provider that authorization is not required. See the section on "Notification Requirements" within this policy.

c. Delegates must allow Members direct access to Specialists, appropriate for their condition and identified need for special healthcare needs.

d. Delegates shall ensure Members have access to American Indian Health Services Programs (AIHSP). AIHSP, whether contracted or not, can provide referrals directly to network Providers without first requesting a referral from a PCP.

5. **Medical Necessity Determination:** Delegates must determine medical necessity for a specific requested service as follows:[47]

a. Employ IEHP-approved UM authorization guidelines, as outlined in this policy, and utilize the following definition for determining medical necessity of a healthcare service:[48]

[45] https://www.accessdata.fda.gov/scripts/cder/daf/
[46] Title 45 Code of Federal Regulations (CFR) 147.130 "Coverage of Preventive Health Services"
[47] NCQA, 2024 HP Standards and Guidelines, UM 1, Element A, Factor 5
[48] CA Welfare and Institutions Code (Welf. & Inst. Code) § 14059.5

1) A service is "medically necessary" or a "medical necessity," when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

b. If information reasonably necessary to make a determination is not available with the referral, the requesting Provider should be contacted for the additional clinical information by telephone at least two (2) times and with a third attempt being made by a Medical Director. The request for additional information must be annotated and include the date of request.[49]

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

d. Obtain input from Specialists in the area of the health care services requested either through an UM Committee member, telephonically, or use of an outside service.[50]

6. **Review Process and Timeframes:** Mandated timeframes for decisions including approval, denial or partial approval (modification) of a request and subsequent notification to the Member and Provider are outlined in this Provider Manual (see "UM Timeliness Standards – Medi-Cal" found on the IEHP website[51]).

a. The prior authorization process is initiated when the Member's Physician requests a referral or authorization for a procedure or service. Please see Policies 14A1, "Review Procedures – Primary Care Provider Referrals" and 14D, "Pre-Service Referral Authorization Process" for more information.

b. Delegates may extend the authorization timeframe by up to fourteen (14) calendar days if:

1) The Member or the Provider requests an extension; or

2) The Delegate can justify its need for additional information and demonstrate how the extension is in the Member's interest.

If the Member requires an extension of the initial authorization timeframe, the Delegate must immediately notify the requesting Provider to request all specific information the Delegate still needs to make its authorization decision. Delegates must provide documentation of the justification of such extension, upon request.

Using the "CCA Notice of Action" template, the Delegate must notify the Member and requesting Provider within the required timeframe, or as soon as the Delegate becomes aware that it will not meet the initial authorization timeframe, whichever is

[49] NCQA, 2024 HP Standards and Guidelines UM 6, Element A
[50] NCQA, 2024 HP Standards and Guidelines, UM 4, Element F, Factors 1 and 2
[51] https://www.iehp.org/en/providers/provider-resources?target=forms

earlier.[52] This notification must include the specific information requested but not received, expert reviewer to be consulted, or the additional examinations or tests required before the service can be approved or denied. See the section on "Notification Requirements" within this policy.

c. For concurrent decisions, care shall not be discontinued until the Member's treating Provider has been notified of the plan's decision and a care plan has been agreed upon by the treating Provider that is appropriate for the medical needs of the Member.[53]

d. *Urgent Preservice or Concurrent Requests:* Delegates have forty-eight (48) hours after receipt of an urgent preservice or concurrent request to determine and communicate to the requesting Provider if it meets the following definition for an urgent pre-service or urgent concurrent request.

   1) Member's condition is such that the Member faces an imminent and serious threat to their health, including but not limited to potential loss of 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; [54] or

   2) In the opinion of a Provider with knowledge of the Member's medical condition, delay would subject the Member to severe pain that cannot be adequately managed without the requested care or treatment.

   Examples of requests that may not be downgraded from urgent preservice or urgent concurrent to non-urgent are Hematology/Oncology and Total Fracture Care.

   The determination that a request does not meet the definition of urgent pre-service or urgent concurrent must be made and documented by the RN or physician reviewer. If the request does not meet the definition of urgent pre-service or urgent concurrent, the RN or physician reviewer must successfully communicate to the requesting Provider either telephonically or by fax that the request did not meet the definition of urgent pre-service or urgent concurrent:

   1) Telephonic communication must be documented, including date, time, name of contact person at the Provider's office, name of the RN/LVN, or physician reviewer.

   2) Faxed communication to the Provider should state that the request did not meet the definition of urgent pre-service as outlined above.

   Delegate must notify both the Provider and Member utilizing the IEHP-approved "CCA Notice of Action" template and provide "Your Rights" attachment with all

[52] CA Health & Saf. Code § 1367.01(h)(5)
[53] CA Health & Saf. Code § 1367.01
[54] CA Health & Saf. Code § 1367.01(h)(2)

denials that instructs a Member or Member's representative about the appeal/grievance process. See the section on "Notification Requirements" within this policy.

If accepted as an urgent pre-service or urgent concurrent request, the Delegate must render a decision and notify the Member and Provider as expeditiously as the Member's health condition requires but no more than regulatory timeframes (see "UM Timeliness Standards – Medi-Cal" found on the IEHP website[55]).

e. *Post-Service Decisions (Retrospective Review):* Services that require prior authorization and rendered without such authorization will be reviewed retrospectively to determine medical necessity and/or benefit coverage. This can include out-of-area admissions, continuity of care, and/or services or treatments rendered by a contracted or non-contracted Provider without prior authorization.

1) If a request for retrospective review is received more than one hundred twenty (120) calendar days after the date that the service was rendered, IEHP must direct the Provider to instead submit a request for claims payment.

2) Relevant clinical information must be obtained and reviewed for medical necessity based on IEHP-approved authorization criteria.[56] If medical necessity is not met, denial determinations must be made by the Delegate Medical Director.

3) Both the Member and Provider must be notified of post-service (retrospective review) determinations, using the appropriate "CCA Notice of Action" template. In case of a denial or partial approval of post-service requests, IEHP recommends the following language: "Your Provider's request to approve the services you already received on <MM/DD/YYYY> does not meet the criteria and is not medically necessary. Please note that, as the Member, you are not responsible for paying for any of these services. If you receive a bill from your Provider, please inform <IPA Name> immediately by calling Member Services at <IPA Contact Information, including TTY>." See the section on "Notification Requirements" within this policy.

f. The timeframes for rendering decisions and sending notifications to the Provider and Member are outlined in this Provider Manual (See "UM Timeliness Standards – Medi-Cal" found on the IEHP website[57]). These timeframes allow the Member sufficient time to request Aid Paid Pending, if applicable.

[55] https://www.iehp.org/en/providers/provider-resources?target=forms
[56] NCQA, 2024 HP Standards and Guidelines, UM 6, Element A
[57] https://www.iehp.org/en/providers/provider-resources?target=forms

7. **Out-of-Network/Capitated Providers**: Prior to redirecting a referral from an out-of-network provider or tertiary facility to a contracted or capitated Provider, the Delegate must first verify and document the following:
   a. That the redirected Provider is of the same discipline and able to provide equivalent service dependent on the Member's medical condition; and
   b. That the Member can receive services within IEHP's access standards. Please see Policy 9A, "Access Standards" for more information.

   Documentation of the above must include:
   a. Name and title of contact at Provider's office;
   b. Date of outreach;
   c. Expected date of Member's appointment; and
   d. Confirmation that the Provider is of the same discipline and able to provide equivalent service dependent on the Member's medical condition.
8. **Notification Requirements**: Any decision to deny a service authorization based on medical necessity or to authorize a service that is less than requested in an amount, duration, or scope must be reviewed and approved by the Delegate Medical Director or physician designee.[58, 59] Members and Providers must receive denial letters for any requested referral that is denied or modified.
   a. All IEHP-approved notification templates are available online at www.iehp.org. The Delegate is responsible for ensuring they are utilizing the most recent version of the template. Notices of Action must adhere to the following:
      1) Include required DMHC language (in bold within template online);
      2) Written in a manner, format, and language that can be easily understood; [60,61,]
      3) Fully translating the Covered California (CCA) Notice of Action including the clinical rationale for the health plan's decision, in the Member's required language;
      4) Include information about how to request translation services and alternative formats, which shall include materials that can be understood by persons with limited English proficiency;[62]

[58] CA Health & Saf. Code § 1367.01
[59] NCQA, 2024 HP Standards and Guidelines, UM 4, Element A
[60] NCQA, 2024 HP Standards and Guidelines, UM 7, Element B, Factor 1
[61] NCQA, 2024 HP Standards and Guidelines, UM 7, Element E, Factor 1
[62] Ibid.

5) Include the right to appeal the decision, file a grievance, ask for an Independent Medical Review (IMR), refer to "Your Rights;"[63, 64,65]

6) Include language appropriate for the Member population describing the reason for the denial:

- Medical necessity denials must cite the criteria used and the reason why the clinical information did not meet criteria;[66,]
- Non-covered benefit denials must cite the specific provision in the Evidence of Coverage (EOC) (i.e., the IEHP Covered California Member Handbook)or State or Federal regulations that exclude that coverage including the section.
- Information on how the Member and Provider can obtain the utilization criteria or benefits provision used in the decision;[67]
- Member-specific denial language should be at a readability level of 6th grade and should not include CPT Codes and abbreviations; and

7) Information for the Member regarding alternative direction for follow-up care or treatment.

b. The written communication to a Provider of a denial based on medical necessity must include the name and telephone number of the UM Medical Director or physician designee responsible for the denial.[68] Such communication must offer the requesting Provider the opportunity to discuss with the physician reviewer any issues or concerns regarding the decision.[69] This written notification of denial or partial approval (modification) must include language informing the Provider of the appeal process. [70,71] See Section 16, "Grievance and Appeals Resolution System" for more information.

c. On a monthly basis, for monitoring purposes, the Delegate must send to IEHP all documentation for each denial including the following. Please see Policy 25E2, "Utilization Management – Reporting Requirements" for more information.
   1) Referral Universe;
   2) Letters and attachments;

[63] CA Health & Saf. Code § 1367.01
[64] NCQA, 2024 HP Standards and Guidelines, UM 7, Element C
[65] NCQA, 2024 HP Standards and Guidelines, UM 7, Element F
[66] CA Health & Saf. Code § 1367.01
[67] NCQA, 2024 HP Standards and Guidelines, UM 7, Element B, Factor 3
[68] CA Health & Saf. Code § 1367.01
[69] NCQA, 2024 HP Standards and Guidelines, UM 7, Element A
[70] NCQA, 2024 HP Standards and Guidelines, UM 7, Element C
[71] NCQA, 2024 HP Standards and Guidelines, UM 7, Element F

3) Clinical documentation;
4) Referral;
5) Outreach/call logs, if any
6) Supporting evidence of the following:
   - Received Date;
   - Decision Date and Time;
   - RN/LVN or physician reviewer note from medical management system; and
   - Proof of date and time letter was mailed to the Member
7) Criteria used for the determination
8) Initial notification including opportunity to discuss; and
9) Audit trail to include all changes and dates made to the case.

Over and Under Utilization Monitoring

A. Delegates must collect, report, and analyze UM data related to Members for potential over or under utilization.
   1. UM data reported includes, at a minimum, the following:
      a. Enrollment;
      b. Re-admits within thirty (30) days of discharge;
      c. Total number of prior authorization requests;
      d. Total number of denials;
      e. Denial percentage;
      f. Emergency encounters; and
      g. Disease-specific over and under utilization metrics.
   2. Delegate must present the above data in summary form to its UM Committee for review and analysis at least quarterly;
   3. Delegates must present selected data from above to its PCPs, Specialists, and/or Hospitals as a group, e.g., Joint Operations Meetings (JOMs), or individually, as appropriate; and
   4. Delegates must be able to provide evidence of review of data above by its UM Committee for trends by physician for both over-utilization and under-utilization.

Other UM Program Requirements

A. **Referral Requests:** PCPs are responsible for supervising, coordinating, and providing initial primary care to patients; for initiating referrals; for maintaining the continuity of patient care, and for serving as the Medical Home for Members. PCP and Specialist requests for referral to specialty care should be initiated through the Member's IPA. Please see Policies 14A1, "Review Procedures – Primary Care Provider (PCP) Referrals" and 14D, "Pre-Service Referral Authorization Process."

B. **Continuity of Care:** IEHP must maintain policies and procedures that ensure Members are given the option to continue treatment for up to twelve (12) months with an out-of-network provider per DHCS requirements. Please see Policy 12A2, "Coordination of Care – Continuity of Care."

C. **Standing Referrals**: IEHP must have policies and procedures by which a PCP may request a standing referral to a Specialist for a Member who requires continuing specialty care over a prolonged period of time or an extended referral to a Specialist or specialty care center for a Member who has a life threatening, degenerative, or disabling condition that requires coordination of care by a Specialist.[72] IEHP must have a system in place to track open, unused, and standing referrals. Please see Policy 14A2, "Standing Referral and Extended Access to Specialty Care" for more information.

D. **Second Opinions:** IEHP provides for its Members second opinion from a qualified health professional within the network at no cost to the Member or arranges for the Member to obtain a second opinion outside of the network, if services are not available within the network.[73] Refer to Policy 14B, "Second Opinions," for more information.

E. **Vision Services**: IEHP is responsible for utilization management associated with vision services for Covered California Members.

F. **Communication Services**: IEHP and its Delegates must provide access to staff for Members and Providers seeking information about the UM process and the authorization of care by providing these communication services: [74]

1. IEHP and its Delegates shall maintain telephone access for Providers to request authorization for healthcare services.[75]

2. IEHP and its Delegates' UM staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.[76] Communications received after normal business hours will be returned on the next business day.

[72] CA Health & Saf. Code § 1374.16
[73] NCQA, 2024 HP Standards and Guidelines, MED 1, Element C
[74] NCQA, 2024 HP Standards and Guidelines, UM 3, Element A, Factors 1 through 5
[75] CA Health & Saf. Code § 1367.01
[76] NCQA, 2024 HP Standards and Guidelines, UM 3, Element A, Factor 1

3. Outbound communication from staff regarding inquiries about UM are made during normal business hours;
4. Staff identify themselves by name, title, and organization when initiating or returning calls regarding UM issues.[77]
5. Staff can receive inbound communication regarding UM issues after normal business hours.
6. There is a toll-free TDD/TTY service for Members who are deaf, hard-of-hearing, or speech-impaired.[78]
7. Language assistance is available for IEHP Members to discuss UM issues.[79]

IEHP will audit to assure that all policies and procedures state that IEHP and its Delegates have these services in place.

G. **Rescinding or Modifying Authorization** - Any authorization provided by a Delegate must not be rescinded or modified after the Provider has already rendered the health care service in good faith pursuant to the authorization.[80]

H. **Record Retention:** Delegates shall retain information on decisions, e.g., authorizations, denials or partial approvals (modifications) for a minimum period of ten (10) years.

I. **Documentation of Medical Information and Review Decisions:** IEHP and its Delegates must base review decisions on documented evidence of medical necessity provided by the attending physician. Regardless of criteria, the Member's condition must always be considered in the review decision.[81]

1. **Physician Documentation:** Attending Physicians must maintain adequate medical record information to assist the decision-making process. The requesting Provider must document the medical necessity for requested services, procedures, or referrals and submit all supporting documentation with the request.
2. **Reviewer Documentation:** Delegate reviewers must abstract and maintain review process information in written format for monitoring purposes. Decisions must be based on clinical information and sound medical judgment with consideration of local standards of care. Documentation must be legible, logical, and follow a case from beginning to end. Rationale for approval, partial approval (modification) or denial must be a documented part of the review process. Documentation must also include a written assessment of medical necessity, relevant clinical information, appropriateness of level of care, and the specific criteria upon which the decision was based.

[77] NCQA, 2024 HP Standards and Guidelines, UM 3, Element A, Factor 3
[78] NCQA, 2024 HP Standards and Guidelines, UM 3, Element A, Factor 4
[79] NCQA, 2024 HP Standards and Guidelines, UM 3, Element A, Factor 5
[80] CA Health & Saf. Code § 1371.8
[81] NCQA, 2024 HP Standards and Guidelines, UM 1, Element A, Factor 6

3. **Documentation:** Delegates must have a procedure in place to log requests by date and receipt of information so that timeframes and compliance with those timeframes can be tracked. Delegate documentation of authorizations or referrals must include, at a minimum: Member name and identifiers, description of service or referral required, medical necessity to justify service or referral, place for service to be performed or name of referred physician, and proposed date of service. Delegate documentation must also include a written assessment of medical necessity, relevant clinical information, appropriateness of level of care, and the specific criteria upon which the decision was based. Any denial of a proposed service or referral must be signed by Medical Director or physician designee.
4. **Member Access to Documentation:** Members may request, free of charge, copies of all documents and records the Delegate relied on to make its decision, including any clinical criteria or guidelines used.[82]

J. **Non-Discrimination:** All Members must receive access to all covered services without restriction based on race, color, ethnicity, ethnic group identification, national origin, ancestry, language, religion, sex, age, mental or physical disability or medical condition, gender, gender identity, sexual orientation, claim experience, medical history, claims history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, marital status, or source of payment. Please see Policy 9H3, "Cultural and Linguistic Services – Non-Discrimination" for more information.

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

L. **Affirmative Statement Regarding Incentives:** UM decisions for Members must be based only on appropriateness of care and service and existence of coverage.[83] Delegates do not provide specifically reward Practitioners or other individuals conducting utilization review for issuing denials of coverage or service.[84] Delegates ensure that contracts with physicians do not encourage or contain financial incentives for denial or underutilization of coverage or service.[85] The Affirmative Statement about incentives is distributed annually to all Practitioners, Providers, and employees involved in authorization review, as well as Members.

M. **Economic Profiling:** Economic profiling is defined as any evaluation performed by the physician reviewer based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician reviewer. Delegates that engage in economic profiling must document the activities and information sources used in

[82] 42 CFR § 438.404(b)(2)
[83] NCQA, 2024 HP Standards and Guidelines, MED 9, Element E, Factor 1
[84] NCQA, 2024 HP Standards and Guidelines, MED 9, Element E, Factor 2
[85] NCQA, 2024 HP Standards and Guidelines, MED 9, Element E, Factor 3

this evaluation and ensure that decisions are rendered, unhindered by fiscal and administrative management.[86]

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

Grievance and Appeals Process

A. IEHP maintains a formal Appeals and Grievance Resolution System to ensure a timely and responsive process for addressing and resolving all Member grievances and appeals. The Member may file an appeal or grievance by phone, by mail, fax, website, or in person. Please refer to Section 16, "Grievance and Appeal Resolution System."

B. A Member or Provider who is not able to obtain a timely referral to an appropriate Provider can file a complaint with the DMHC:[87]

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

Monitoring Activities and Oversight

A. IEHP monitors and oversees delegated UM activities performed by its Delegates. The following oversight activities are performed to ensure compliance with IEHP UM and regulatory standards:

1. **Delegation Oversight Audits (DOA)** – IEHP performs a Delegation Oversight Audit of its Delegates' UM program and objectives, policies, procedures, activities and their progress. This audit re-assesses the Delegates' operational capabilities in the areas of UM and other delegated activities. Please refer to Policy 25A1, "Delegation Oversight Audit" for further details.
2. **Analysis of Provider Data Reports** – Through its delegation oversight process, IEHP reviews health plan and Delegate reports and utilization data including second opinion tracking logs, referral universes and letters, annual and semi-annual work plans. Provider reports and utilization data is subsequently reviewed by the Delegation Oversight Committee (DOC).
3. **Review of Approvals and Denials** – IEHP and its Delegates are required to submit a monthly Referral Universe from which authorizations are selected for review. Please refer to Policy 25E2, "Utilization Management – Reporting Requirements" for more information.

[86] CA Health & Saf. Code § 1367.02
[87] CA Health & Saf. Code § 1367.031(e)(2)(C)

4. **Focused Referral and Denial Audits:** IEHP performs focused audits of the referral and denial process for Delegates. Please refer to Policy 25E3, "Referral and Denial Audits." Audits examine source data at the Delegate to determine referral process timelines and appropriateness of denials and the denial process, including denial letters.
5. **Member or Provider Grievance Review:** IEHP performs review, tracking, and trending of Member or Provider grievances and appeals related to UM. IEHP reviews Delegate grievances and recommended resolutions for policies, procedures, actions, or behaviors that could potentially negatively impact Member health care.
6. **Joint Operations Meetings (JOMs):** JOMs are intended to provide a forum to discuss issues and ideas concerning care for Members. They allow IEHP a method of monitoring plan administration responsibilities delegated to Delegates. JOMs may address specific Provider Experience, UM, QM, CM, grievance, study results, or any other pertinent quality issues affecting Providers, Hospitals or Delegates. They are held with Delegates and Hospital partners, as applicable. These meetings are designed to address issues from an operational level.
7. **Satisfaction with the UM Process**: At least annually, IEHP performs Member and Provider Experience Surveys as a method for determining barriers to care and/or satisfaction with IEHP processes including UM.

B. Enforcement/Compliance: IEHP monitors and oversees delegated UM activities performed by Delegates. Enforcing compliance with IEHP standards is a critical component of monitoring and oversight of IEHP Providers, particularly related to delegated activities. Delegates that demonstrate a consistent inability to meet standards can be subject to contract termination.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2024	
Revision Effective Date:		