6. FACILITY SITE REVIEW

A. Facility Site Review and Medical Record Review Survey Requirements and Monitoring

APPLIES TO:

A. This policy applies to all Primary Care Providers (PCPs) who provide care and services to IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. Managed Care Plans (MCP) conduct Facility Site Review (FSR) and Medical Record Review (MRR) surveys on all PCP sites to ensure their capacity to support the safe and effective provision of primary care services (See, "DHCS MMCD Facility Site Review (FSR) Standards" and "DHCS MMCD Medical Record Review (MRR) Standards" found on the IEHP website).[1]

DEFINITIONS:

A. Delegate – For the purpose of this policy, this is a health plan delegated to perform activities outlined in this policy.

B. Supplemental Facilities– Supplemental facilities include mobile, satellite, school-based, and other extension clinics. These facilities assist in the care delivery of primary care services to geographically remote areas that lack health care services, as well as assist the underserved population in areas where there may be access to care concerns. These facilities may offer a variety of clinical services including, but not limited to preventive care, immunizations, screenings, and/or chronic care management (excluding specialty services).

C. Mobile Clinics – Self-contained units including vans, recreational vehicles, and other vehicles that have been repurposed to provide space for various clinic services and may also serve to deliver equipment to locations that operate temporary clinics.

D. Street Medicine Provider - refers to a licensed medical provider (e.g., Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM)) who conducts patient visits outside of the four walls of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be (such as those living in a car, RV, abandoned building, or other outdoor areas).

E. Shared Medical Records Practice – This practice occurs when multiple PCPs see the same patients and use the same medical records for documentation of patient care.

PROCEDURES:

IPA and Delegate Responsibilities

A. IPAs' and Delegates' credentialing responsibilities include obtaining evidence of current and valid site and medical record reviews for all PCPs, as applicable, in accordance with regulatory standards.

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

B. Delegates are responsible for conducting FSR/MRR for their PCPs.

C. IPAs and Delegates must have policies and procedures that document their review process, including a description of their site and medical records review requirements.

D. IEHP verifies IPA and Delegate compliance with the requirements listed above, during the annual review of their Quality Management Program Description, Evaluation and Work Plan, as well as during the Delegation Oversight Annual Audit. See Policies 25A2, "Delegation Oversight - Audit" and 25D2, "Quality Management – IPA Quality Management Program Structure Requirements."

IEHP Responsibilities

A. All PCP sites in the IEHP network must pass their initial and subsequent site reviews, consisting of an FSR and MRR. For every new and continually contracted PCP site, IEHP ensures that:

1. Each PCP site passes an initial FSR and, as applicable, corrects all deficiencies in order to close their Corrective Action Plan (CAP) prior to being added to the IEHP network and receiving assignment of Medi-Cal membership.

2. Each PCP site completes an initial MRR after the PCP is assigned Members, and, as applicable, submits all appropriate documentation to address all deficiencies to close their CAP.

3. Each PCP site completes periodic subsequent site reviews consisting of both a FSR and MRR at minimum, at least every three (3) years thereafter, unless it was determined that the PCP be placed on an annual review. No PCP or non-participating provider will be able to provide care and services at sites without completing an FSR/MRR.

4. Supplemental facilities complete an initial site review and subsequent site reviews at least every three years thereafter, with a focus on areas relevant to the services being provided by the supplemental facilities.

B. An initial FSR and/or MRR may be waived if the PCP has documented proof that another MCP completed an FSR and/or MRR within the past three (3) years and the PCP received a passing score.

C. Street medicine Providers who are serving in an assigned PCP capacity are required to undergo the appropriate level of site review process, which is either a full or a condensed review.

1. For street medicine Providers serving as an assigned PCP, and that are affiliated with a brick-and-mortar facility or that operate a mobile unit/RV, the MCP must conduct the full review process of the street medicine Provider and affiliated facility in accordance with APL 22-017.

2. For street medicine Providers serving as an assigned PCP, and that are not affiliated with a brick-and-mortar facility or mobile unit/RV, the MCP must conduct a condensed Facility Site Review (FSR) and Medical Record Review (MRR) of the street medicine Provider to ensure Member safety. The requirements for the condensed FSR and MRR that MCPs must adhere to as part of their review processes is forthcoming and will be limited to FSR and MRR requirements that would apply only to a street medicine Provider under this scenario. The condensed FSR and MRR requirements will be based on and reflective of the full FSR and MRR requirements as outlined in APL 22-017.

6. FACILITY SITE REVIEW

A. Facility Site Review and Medical Record Review Survey Requirements and Monitoring

D. PCPs classified as No Assignment Primary Care Providers (NA PCPs), who do not have responsibilities as a PCP for preventive services, are not subject to a Facility Site Review/Medical Record Review (FSR/MRR). These PCPs would include but are not limited to:

1. Practitioners added to a Specialist Contract treating Members for discharge services on behalf of the Specialist Group.
2. Practitioners contracted to admit patients (Admitters) on behalf of the IPA network.
3. Practitioners that function as PCPs but do not receive assignment because they have met capacity of IPA affiliations for the line of business.
4. Practitioners that function as a PCP but do not receive assignment because they do not meet the Sixteen (16) office hour requirement.

E. Scenarios that require an initial site review include, but are not limited to:

F. A new PCP site is added to the network.

1. A newly contracted Provider assumes a PCP site with a previous failing FSR and/or MRR score within the last three (3) years.
2. A PCP site is returning to the Medi-Cal managed care program and has not had a passing FSR in the last three (3) years.
3. At the discretion of the MCP, a separate site review may be conducted for solo practices/organizations.
4. Upon identification of multiple independent practices that occupy the same site, a separate site review must be completed for all PCP practices at the site and a unique alphanumeric DHCS Site ID will be assigned for each independent PCP practice at the site if ownership is different.
5. A change in ownership of an existing Provider site is planned or identified.
6. A PCP site relocates.
7. A new MCP is established or an existing MCP expands to a new service area. New MCPs and those that expand to a new area must complete an initial site review on a specified number of PCP sites.

G. IEHP and other local MCPs have collaboratively developed and maintained a standardized system of conducting FSRs and MRRs of shared PCPs that minimize duplication of review efforts. Each collaborative MCP determines whether to accept another MCP's FSR and/or MRR findings.

H. The FSR and MRR Survey is scheduled directly with the PCP office and the Providers are notified in advance of site reviews and whether the site review is conducted by DHCS or IEHP.

I. FSR and MRR are conducted by Certified Site Reviewers (CSRs) and/or Certified Master Trainers (CMTs). IEHP maintains (a) designated Physician(s), Nurse Practitioner(s), Physician Assistant(s) or registered nurse(s) as CMTs who are responsible for training and supervising CSRs. CMTs are also responsible for certifying, monitoring, and evaluating nurse and Physician reviewers for inter-rater reliability.

J. Residency Teaching Clinics, Federally Qualified Health Center (FQHC), and Rural Health Clinics are also subject to the FSR and MRR Survey. See Policies 6D, "Residency Teaching Clinics," and 6E, "Rural Health Clinics."

Facility Site Review (FSR)

A. The FSR Survey is used to verify the following site and compliance information, and assign scores accordingly (see, "DHCS MMCD Facility Site Review Tool" found on the IEHP website):[2]

1. Access and Safety;
2. Personnel;
3. Office Management;
4. Clinical Services;
5. Preventive Services; and
6. Infection Control.

B. Critical elements related to the potential for adverse effect on patient health or safety and therefore, have a scored "weight" of two (2) points. All other survey criteria are weighted at one (1) point. Critical elements include the following 14 criteria:

1. Exit doors and aisles are unobstructed and egress (escape) accessible;
2. Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe, and Ambu (Artificial manual breathing unit) bag, appropriate to practice/patient population is available on site;
3. Emergency medicine such as asthma, chest pain, hypoglycemia and anaphylactic reaction management: Epinephrine 1:1000 (injectable), and Benadryl 25 mg. (oral) or Benadryl 50 mg./ml. (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose containing at least 5 grams of glucose. Appropriate sizes of ESIP needles/syringes and alcohol wipes;
4. Only qualified/trained personnel retrieve, prepare or administer medications;
5. Office practice procedures are utilized on-site that allow timely provision and tracking of physician review and follow-up of referrals, consultation reports and diagnostic test results;
6. Only lawfully authorized persons dispense drugs to patients;
7. Drugs and vaccines are prepared and drawn only prior to administration;
8. Personal protective equipment (PPE) for standard precautions is readily available for staff use;
9. Needlestick safety precautions are practiced on- site;

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

10. Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazardous non-sharps) are placed in appropriate leak-proof, labeled containers, for collection, handling, processing, storage, transport or shipping;
11. Staff demonstrate /verbalize necessary steps/process to ensure sterility and/or high-level disinfection to ensure sterility/disinfection of equipment;
12. Appropriate PPE is available, exposure control plan, medical safety data sheet (MSDS) and clean up instructions in the event of a cold chemical sterilant spill.
13. Spore testing of autoclave/steam sterilizer with documented results is completed (at least monthly), unless otherwise stated in the manufacturers guidelines, with documented results
14. Management of positive mechanical, chemical, and/or biological indicators of the sterilization process.

C. If deficiencies are found in any of the 14 critical elements during the survey, focused review survey, or monitoring visit, the PCP must submit a Corrective Action Plan (CAP) and evidence of corrections within 10 calendar days of the survey date. The CSR or CMT must conduct a focused review to verify that CAPs for critical elements are completed within 30 calendar days from the date of the FSR and/or MRR report.

D. Sites found deficient in any critical element during the survey are required to address 100% of the survey deficiencies, regardless of survey score.

E. Any PCP whose site review reveals significant quality of care issues any issue identified by the CMT or CSR that is not captured in the FSR is not eligible for participation in IEHP's network, pending the outcome of a review by IEHP's Peer Review Subcommittee.

F. All PCP sites are assessed for specific physical access requirements for Seniors and Persons with Disabilities initially and every three (3) years thereafter. See Policy 6B, "Physical Accessibility Review Survey."

Medical Record Review (MRR)

A. MRRs are performed at the time of the FSR if medical records are available.

1. MRRs are performed within 90 calendar days of the PCP's effective date with IEHP.
2. An additional extension of 90 calendar days may be allowed only if the new Provider does not have a sufficient number of Members assigned to complete a review of 10 medical records.
3. If there are still fewer than 10 assigned Members after six (6) months from the PCP's effective date, an MRR is completed on the total number of records available and the scoring is adjusted according to the number of records reviewed.
4. The MRR score is based on a standard review of 10 randomly selected medical records per Provider, consisting of five (5) pediatric and five (5) adult or obstetric medical records. For PCP sites serving only pediatric or only adult patients, all 10 medical records must be reviewed using the appropriate preventive care criteria.

6. FACILITY SITE REVIEW

A. Facility Site Review and Medical Record Review Survey Requirements and Monitoring

B. The MRR survey verifies the following medical record and compliance information (see, "DHCS MMCD Medical Record Review Tool" found on the IEHP website):[3]

1. Format;
2. Documentation;
3. Coordination/Continuity of Care;
4. Pediatric Preventive (as appropriate);
5. Adult Preventive (as appropriate); and
6. OB/CPSP (Comprehensive Perinatal Services Program) Preventive (when applicable).

C. During the MRR, site reviewers have the option to request additional medical records for review to ensure adequate review of all Provider specialties, Member populations, etc. If the site reviewer chooses to review additional medical records, the MCP must calculate the scores accordingly. Medical records are selected randomly by using a Member Assignment List (Eligibility List).

D. IEHP may choose to conduct the MRR portion of the site review onsite or virtually complying with all applicable HIPAA standards. Both onsite and virtual MRR may include the review of medical records for Members belonging to another MCP, and may include the viewing, collection, storage, and transmission of Protected Health Information (PHI).

E. Sites, where documentation of patient care by multiple PCPs occurs in the same record, are reviewed as a "shared" medical record system. Shared medical records are considered those that are not identifiable as "separate" records belonging to any specific PCP:

Number of PCPs	Minimum number of medical records (based on the general patient population distribution: pediatrics, adult, obstetrics)
1-3	10
4-6	20
7+	30

F. For group practices, where PCPs do not share charts, each PCP must be reviewed separately and receive a separate score. A minimum of 10 charts are reviewed for each PCP.

G. If a minimum number of records are not available for review due to limited patient population, the reviewer will complete the MRR, document the rationale, and adjust the score as needed.

H. For group practices with mixed specialties, medical records are requested based on the different types of specialties in the office and DHCS regulations of the number of required adult Members and pediatric Members for review.

1. MRR Survey Addendum

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

6. FACILITY SITE REVIEW

A. Facility Site Review and Medical Record Review Survey Requirements and Monitoring

a. All PCPs that provide obstetric (OB) services are required to undergo an audit specific to OB site and medical record requirements, utilizing the IEHP MRR Survey Addendum tool for PCP/OB/FP1/FP2. For OB/GYNs acting as PCPs and PCPs providing obstetric care in accordance with American College of Obstetricians and Gynecologists and Comprehensive Perinatal Services Program standards, all medical records must be reviewed using preventive criteria for adults or pediatrics (pregnant Members under 21 years) and obstetrics. The medical record portion of the DHCS audit, OB/CPSP Preventative Preventive Criteria section verifies PCP-OB compliance with IEHP's policies and procedures regarding Perinatal OB/CPSP Preventive Care including:

1) Prenatal care assessments to include blood pressure (BP), fundal height, fetal heart tones and maternal complications;

2) Postpartum care assessments to include weight, BP, breast exam, abdomen or pelvic exam, depression and family planning.

Scoring

A. Scores are issued based on established scoring procedures, located in the FSR and MRR review tools. Compliance level categories for FSR and MRR score results are as follows:

	Exempted Pass	Conditional Pass	Fail (Not Pass)
FSR	• Score of 90% and above without deficiencies in Critical Elements, pharmacy or infection control • CAP not required	• Score of 90% and above with deficiencies in Critical Elements (CE), pharmacy or infection control • Score of 80-89% regardless of deficiencies • CAP required	• Score of 79% or below • CAP required
MRR	• Score of 90% and above with all section scores at 80% or above • CAP not required	• Score of 90% and above with one or more section score below 80% • Score 80-89% • CAP required	• Score below 79% or below • CAP required
MCPs may require a CAP regardless of score for other findings identified during the survey that require correction.			

B. The FSR Survey contains a total of 170 points. Total MRR survey points will vary based on the number and type of charts reviewed (i.e., Peds vs Adults vs OB/CPSP).

C. PCPs with scores below 80% are placed on an annual review and will have their panels frozen to accept new Member assignments until corrections are verified and the CAP is closed.

D. A site that scores below 80% on their initial FSR and/or MRR Survey is considered a "failed site."

Providers who do not pass the initial FSR after two (2) attempts may re-apply with IEHP after six (6) months. At the discretion of IEHP, additional training and technical assistance may be provided.

E. For existing sites that score below 80% on the FSR and/or MRR Survey, the sites will be placed on an annual review cycle. However, IEHP reserves the right to remove PCPs from the network and transfer Members to other PCPs as necessary to protect the health and safety of Members.

1. PCP sites that score below 80% in either FSR or MRR for two (2) consecutive reviews will receive a CAP notification letter. Sites must score a minimum of 80% on their next annual FSR and MRR or the PCP will be terminated from the IEHP network.

   a. Should the PCP be allowed to remain in the network, survey deficiencies must be corrected by the PCP, then approved and verified and approved by IEHP.

   b. PCP sites that score below 80% in either FSR or MRR for three (3) consecutive reviews will be terminated from the IEHP network.

   c. IEHP reserves the right to further monitor PCP sites scoring 80% or above on their 2nd annual review through the quality monitoring process if there are any issues or concerns identified which include but are not limited to: an additional annual FSR/MRR or focused audit.

F. All FSR and MRR scores are based on available documented evidence, demonstration of the criteria, and verbal interviews with site personnel. If a site reviewer chooses to review additional criteria not included in the FSR or MRR tools, the site reviewer must not include the additional criteria in the existing scoring method. MCPs must not alter scored criteria or assigned weights in any way.

G. PCP sites that successfully pass both their FSR and MRR, and have closed all CAPs, are issued a Certificate of Completion. The certificate is dated based on the most recent FSR, is valid for up to three (3) years and affirms that a site has been deemed a DHCS Certified Provider site.

H. If a site's Certification is revoked as a result of noncompliance with applicable requirements, the site is no longer deemed a DHCS Certified Provider Site and will not be allowed assignment of Member as a PCP until the PCP site has successfully completed the FSR/MRR and closed all CAPs.

Corrective Action Plan (CAP)

A. The PCP receives a CAP notification letter at the time the survey is performed. Any deficiencies found during the FSR are noted on the form (See, "Corrective Action Plan Notification Tool" found on the IEHP website).[4] The CAP notes the PCP compliance status, timeframes for corrective action, and any other pertinent information.

1. CAPs for critical elements must be given at time of audit.

2. CAPs for all non-critical element deficiencies are issued within 10 calendar days of survey completion.

B. After passing the initial FSR, all CAPs must be closed prior to receiving assignment of Medi-Cal Members.

C. New members will not be assigned to providers who do not correct site review deficiencies within the

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

established CAP timelines.

D. Sites that receive an "Exempted Pass" are not required to complete a CAP unless determined necessary by the CSR. All sites that receive a "Conditional Pass" are required to submit a CAP to IEHP to address 100% of cited deficiencies within 30 calendar days from the date of the FSR/MRR report.

E. At the discretion of IEHP, a CAP may be requested for other findings identified during the survey that require correction, regardless of FSR and/or MRR score. There is no rescoring of the FSR or MRR as deficiencies are corrected or addressed, and points are still deducted even if deficiencies are corrected at the time of the audit.

F. CAPs are also required when there are CE, pharmacy, and infection control deficiencies found during any site review activity, including but not limited to, focused reviews, monitoring activities, or other reviews done by IEHP or DHCS.

CAP Verification Process

A. A CAP must be submitted for all FSR and MRR Survey scores of 80-89% or 90% and above with deficiencies in critical elements, pharmacy and/or infection control or individual medical record sections scoring below 80%. The MCP that completed the FSR/MRR is responsible for follow-up, closure of the CAPs, and interim reviews. CAP documentation must identify:

1. The specific deficiency;
2. Corrective actions needed;
3. Projected and actual dates of the deficiency correction;
4. Reevaluation of timelines and dates; and
5. Responsible persons.

B. CAPs for non-critical elements may be verified via document submission. CAPs for critical elements must be verified onsite.

C. Closed CAP documentation must include:

1. Documentation of problems in completing corrective actions (if any);
2. Resources and technical assistance provided by the MCP;
3. Evidence of the corrections;
4. Completion and closure dates; and
5. Name and title of the MCP reviewer.

D. IEHP, at its discretion, may continue to monitor PCP sites after it has met the threshold for Conditional Pass and the CAP response has been verified and approved.

E. The CSR or CMT is also responsible for reviewing the CAP with the PCP as well as finalizing, scoring, and signing the CAP.

F. At the CSR's discretion, if the CAP cannot be verified by the PCP's submission of definitive proof, then the CSR will go on site to obtain proof of CAP completion.

G. MCPs must follow the time below for CAP notification and completion:

6. FACILITY SITE REVIEW

A. Facility Site Review and Medical Record Review Survey Requirements and Monitoring

CAP Timeline	CAP Action(s)
Day of the FSR and/or MRR	The MCP must provide the PCP site with the following: • Verbal notification of any CE findings and a signed attestation by the PCP/site designee and the MCP staff confirming that a discussion regarding CE findings occurred. (This serves as the start of the CE-CAP timeline). • A formal written request for CAPs to address all CEs, if applicable, the day of the site visit but no later than one business day after site visit completion. • The FSR score the day of the site visit but not later than one business day after site visit completion. • The MRR score the day of site visit but no later than one business day after MRR completion.
Within 10 business days from the date of completing FSR visit and/or MRR	• The PCP site must submit a CAP and evidence of corrections to the MCP for all deficient critical elements, if applicable. • The MCP must review, approve, or request additional information on the submitted CAP(s) for CE findings. • The MCP must provide a report to the PCP site containing FSR and/or MRR findings, along with a formal written request for CAPs for all non-CE deficiencies. (This serves as the start of the non-CE CAP timeline). • The MCP must provide educational support and technical assistance to PCP sites as needed.
Within 30 calendar days from the date of the completed FSR	• The MCP must verify that all aspects of CE CAPs are completed. • Providers can request a definitive, time-specific extension period to correct CE deficiencies, and to be granted at the discretion of the MCP, not to exceed 60 calendar days from the date of the FSR.

6. FACILITY SITE REVIEW

A. Facility Site Review and Medical Record Review Survey Requirements and Monitoring

CAP Timeline	CAP Action(s)
Within 30 calendar days from the date of the FSR and/or MRR report	• The PCP must submit a CAP for all non-CE (FSR/MRR) deficiencies to the MCP. • The MCP must provide educational support and technical assistance to PCP sites as needed.
Within 60 calendar days from the date of the FSR	• For those sites that were granted an extension for CE CAPs, the MCP must verify that all CE CAPs are closed.
Within 60 calendar days from the date of the FSR and/or MRR report	• The MCP must verify that non-critical CAPs are completed. • The MCP must review, approve, or request additional information on the submitted CAP(s) for non-critical findings. • The MCP must continue to provide educational support and technical assistance to PCP sites as needed.
Within 90 calendar days from the date of the FSR and/or MRR report	• All non-critical CAPs must be closed. • Providers can request a definitive, time-specific extension period to complete the CAP(s), not to exceed 120 calendar days from the date of the initial report of FSR and/or MRR findings.
Beyond 120 calendar days from the date of the FSR and/or MRR report	• Under extenuating circumstances, MCPs can request from DHCS a definitive, time-specific extension period to allow for 1) the PCP site to complete the CAP and/or 2) the MCP to verify CAPs have been completed. • The MCP must conduct another FSR and/or MRR, as applicable, within 12 months of the applicable FSR and/or MRR date(s).

Non-Compliant Provider

A. Any PCP who does not come into compliance with survey criteria within the established CAP timelines must be removed from the network and their Members will be appropriately reassigned to other network providers.

B. Any PCP that fails the FSR and/or MRR surveys, or is non-compliant with CAP timelines, will be reported to Medi-Cal MCP collaborative partners.

C. PCPs termed by IEHP for FSR and MRR Survey noncompliance may also be termed by all affiliated Medi-Cal MCPs.

D. Members will not be assigned to PCPs who do not correct survey deficiencies within established CAP timeframes and until IEHP verifies that the PCP has corrected the deficiencies and the CAP is closed.

E. PCP sites that score 79% or below in either FSR or MRR for two (2) consecutive reviews will receive a non-compliance notification letter and must score a minimum of 80% on the next site review in both the FSR and MRR or the PCP will be administratively terminated from the IEHP network.

Provider Relocation

A. When a PCP site relocates, the following must occur:

1. The relocating PCP site is required to undergo an initial site review process.
2. The relocated PCP site must pass the initial FSR within 60 days of notification or discovery of the completed move. IEHP allows the PCP to continue to see their assigned Members however, the PCP site is not assigned new Members until initial site review is completed.
3. Upon passing the initial FSR and closing CAPs, if applicable, the following will occur:
    a. The PCP site may be formally added to the Network.
    b. New and established relocating Members can be formally assigned to the new Provider location.
4. If the relocated PCP site does not pass the initial FSR within two attempts, or does not complete required CAPs per stablished timelines, the following will occur:
    a. The relocated PCP site may not be added to the MCP's Provider Network.
    b. The previous PCP site must be removed from the Network if the site has closed.
    c. Current assigned membership must be reassigned to another Network PCP, if the previous site has closed.
    d. The relocated PCP site may reapply six months from the last FSR survey.

B. Credentialed PCPs who move their offices to new locations are subject to the following:

1. If the new location is not currently an approved IEHP PCP site, the PCP is required to have an initial FSR within 60 days of the effective date of the move or the date IEHP discovers that the PCP site has moved.
2. If the PCP relocating takes his/her medical records to the new location, a new MRR is not required if MRR was done within the past 12 months and the PCP received a passing score. The PCP then retains the MRR score from the previous site.
    a. Current Members will remain assigned to the PCP.
    b. If the PCP does not notify IEHP, at least 30 days prior to the move, then the PCP will be closed to auto-assignment for a minimum of 60 days or until the site audit is completed.

C. PCPs applying for participation in IEHP's network, who join a currently approved IEHP PCP site, are subject to an MRR Survey specific to the new PCP. This is performed 90 to 180 calendar days after the PCP's eligibility date with IEHP, unless records are shared.

D. Unless significant discrepancies are found, only one (1) site survey is performed in the three (3) year period following the most recent full audit for all PCP sites. Additional PCPs joining such sites receive an integrated facility score; however, a focused FSR may be required if the new PCP has a different specialty (i.e., Pediatrics vs Internal Medicine), as issues are identified and/or as requested by another department by IEHP.

On-Site Hours Requirements

A. PCPs must be physically on-site and available for patient care for a minimum of 16 hours per week per site location, as verified by IEHP. Please see Policy 6C, "PCP Sites Denied Participation or Removed from the IEHP Network." Exceptions to this requirement are:

1. Residency Teaching Clinics - Refer to Policy 6D, "Residency Teaching Clinics"; and
2. Rural Health Clinics – Refer to Policy 6E, "Rural Clinics" for more information.

Monitoring

A. IEHP periodically monitors all PCP sites between each regularly scheduled FSR and MRR. Monitoring sites between audits includes the use of both internal quality management systems and external sources of information. The PCP's compliance with the fourteen (14) critical elements is monitored between full surveys through interim, and focused reviews. If deficiencies are identified through monitoring, IEHP will determine the appropriate course of action, such as conducting an onsite or virtual site & medical record review or additional focused reviews, to educate and correct deficiencies according to established CAP timelines. Please see Policy 6H, "Interim FSR Monitoring for Primary Care Providers."

B. Focused Reviews

1. A focused review is an audit used to investigate specific issues identified through quality monitoring, including Member complaints, referral from other internal departments, or to follow up on corrective actions. Reviewers may utilize the appropriate sections of the FSR and MRR tools for the focused review or other methods to investigate identified deficiencies or situations. All deficiencies found in a focused review require the completion and verification of a CAP according to established timelines.
2. IEHP can perform a focused review on any IEHP PCP site, at the discretion of the Plan.
3. DHCS-Conducted Site Reviews
    a. As part of the DHCS' ongoing monitoring of IEHP's process, DHCS nurse auditors may conduct separate onsite site reviews of randomly chosen PCP sites to validate FSR and MRR processes and to monitor IEHP services. Prior notice to the PCP is not required.
    b. DHCS will notify IEHP of critical findings and provide a written report summarizing all of DHCS' review findings.

c. Within 30 calendar days from the date of receipt of the DHCS-conducted site review report, IEHP will provide a CAP to DHCS responding to all cited deficiencies documented in the report. The CAP includes a response to:

1) The identified deficiency(ies).

2) A description of action(s) taken to correct the deficiency(ies).

d. If a deficiency is determined to require long-term corrective action, the response will include indication that IEHP has:

1) Initiated remedial action(s);

2) Developed a plan to achieve an acceptable level of compliance;

3) Documented the date the PCP is in full compliance or when full compliance will be achieved.

C. DHCS Mandated Reporting:

1. IEHP reports its monitoring activities to DHCS semi-annually.

2. PCP site audit information is included in Quality Management reporting.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

6. FACILITY SITE REVIEW

B. Physical Accessibility Review Survey

APPLIES TO:

A. This policy applies to all contracted Primary Care Providers (PCPs), identified high volume Specialists, identified high volume Ancillary sites, Community-Based Adult Services (CBAS), and Urgent Care Center (UCC) Providers, who provide care and services to IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. All contracted PCP sites, identified high volume Specialists, identified high volume Ancillary sites, CBAS, and UCC Providers, must undergo the Physical Accessibility Review Survey (PARS) assessment.

PROCEDURES:

A. Physical Accessibility Review Survey

1. The PARS assessment is performed initially for all new sites and every three (3) years thereafter. For PCPs, the PARS assessment is performed as part of the Facility Site Review and Medical Record Review processes:
    a. For PCPs and Specialists, see, "DHCS MMCD FSR Attachment C - Physical Accessibility Review Survey" found on the IEHP website.[1]
    b. For UCC Providers, Skill Nursing Facilities, and Non-Hospital Based Radiology Centers, see, "DHCS MMCD FSR Attachment D – Ancillary Physical Accessibility Review Survey" found on the IEHP website.[2]
    c. For CBAS Providers, see, "DHCS MMCD FSR Attachment E – CBAS Physical Accessibility Review Survey" found on the IEHP website.[3]
2. IEHP may review sites more frequently based upon request for review due to a significant site remodel or identified grievances related to physical accessibility. In addition, this would apply to all Providers adding or moving locations.
3. After concluding the PARS, the IEHP Reviewer will:
    a. Discuss the PARS findings with the Provider or Office Manager; and
    b. Enter the PARS findings into IEHP's designated database.
4. Results of the PARS assessment are shared with other Managed Care Plans as part of the collaboration process to minimize duplication of assessments.
5. IEHP makes PARS results available to Members on the IEHP website and Provider Directory noting the site as having Basic Access, Limited Access, Medical Equipment

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

Access, as well as Accessibility Indicators such as the following (see, "Physical Accessibility Review Survey" found on the IEHP website).[4]

a. P= Parking;

b. EB= Exterior Building;

c. IB= Interior Building;

d. R= Restroom;

e. E= Exam Room; and

f. T= Exam Table/Scale.

6. The results of all the PARS assessments are informational and unlike the Facility Site Review (FSR) and Medical Record Review (MRR) Surveys, do not require a Corrective Action Plan (CAP) for any deficiencies.

B. Site Reviewer Requirements

1. Reviewer may be an IEHP clinical or non-clinical staff.
2. Reviewer will use the appropriate DHCS PARS tools and guidelines.
3. Reviewer will undergo PARS Training.

C. Provider Education

1. IEHP Nurse Educators will offer on-site PCP and staff education regarding PARS requirements in conjunction with the optional FSR/ MRR training that is offered to PCPs prior to all initial and periodic reviews, as necessary.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	June 1, 2011	
Revision Effective Date:	January 1, 2024	

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

6. FACILITY SITE REVIEW

C. PCP Sites Denied Participation or Removed from the IEHP Network

APPLIES TO:

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

POLICY:

A. IEHP conducts Facility Site Review (FSR) and Medical Record Review (MRR) surveys on all Primary Care Provider (PCP) sites and supplemental facilities to ensure their capacity to support the safe and effective provision of primary care services.[1]

B. IEHP reserves the right to remove PCPs from the network and transfer Members to other PCPs as necessary to protect the health and safety of Members.

PROCEDURES:

A. PCP sites may be removed, limited, or denied participation in the IEHP network under any of the following circumstances listed below:

1. FSR and MRR Surveys
    a. Sites that score:
        1) Below 80% on either the FSR or MRR;
        2) Below 80% on either the FSR or MRR, with a non-compliant Corrective Action Plan (CAP); and
        3) Below 80% on re-assessment of site or medical record review;
    b. Critical element deficiencies which are not corrected;
    c. PCP site does not come into compliance with survey criteria within established Corrective Action Plan (CAP) timeframes; and
    d. PCP site receives a failing score on either the FSR or MRR for two (2) consecutive site reviews and fails on its third consecutive attempt.
2. On-Site Hours
    a. IEHP requires a PCP to be on site at a minimum of 16 hours per week. If a PCP appears to be at the site less than 16 hours per week, the site is closed to new enrollment until IEHP can confirm the PCP meets this requirement.
    b. The PCP and/or IPA must submit a CAP signed by the PCP verifying that they are present at the site a minimum of 16 hours per week. Rural health clinics are exempt from this minimum on-site hours requirement. Please see Policy 6E, "Rural Health

[1] Medicare Managed Care Manual, "Chapter 6 – Relationships with Providers," Section 60.3

Clinics" for more details.

B. PCPs must complete a CAP within established timeframes. PCPs who fail to submit a CAP for on-site hours requirements will be referred to IEHP's Provider Relations team for further action, which may lead to the PCP being administratively removed from the IEHP network.

C. The following actions take place when a site is removed from the IEHP network:

1. The IPA, PCP and all participating Managed Care Plans are notified that the site is removed from the IEHP network.

2. All affected Members are mailed a notification letter informing them of the change and outlining their options. See Policy 18J, "IEHP Termination of PCPs, Specialists, Vision, and Behavioral Health Providers."

D. Pre-contracted providers who do not pass the initial FSR may use the first attempt as a learning and technical assistance opportunity. If the Provider fails the site review after two (2) attempts, the Provider will need to reapply to IEHP six (6) months from the date of the second attempt.

E. PCPs who are administratively removed from or denied participation in the IEHP network for failing an FSR/MRR or failure to meet on-site hour requirements can apply through their IPA to be reconsidered for IEHP participation at either their original site or a new site. The re-application cannot be done until 12 months after a site was terminated from or denied participation in the IEHP network**.** In either case, all conditions below must be met, as applicable:

1. For PCPs who failed an FSR/MRR:

   a. A repeat FSR and MRR Survey will be performed by IEHP within 12 months. The third consecutive attempt must result in a score of 80% or greater in both FSR and MRR. If the PCP site fails on its third consecutive attempt in the PCP site will be terminated from the IEHP network.

   b. Site surveys are scheduled by the Quality Management Department within 60 days of notification from the Credentialing Department if a site has no record of a passing survey score in the past three (3) years.

2. For PCPs found not to be physically present at a site for a minimum of 16 hours per week and do not complete their CAP:

   a. PCPs can re-apply 12 months after being denied participation in the IEHP network, either individually or through their IPA, to be reconsidered to become a participating PCP site.

   b. The PCP must submit directly to IEHP, or through their IPA if applicable, a schedule that covers the most recent six (6) month period (at minimum) and demonstrates that they are on-site at least 16 hours per week.

   c. The IPA must submit a letter signed by the PCP committing to this schedule and

timeframe. PCPs may change the schedule in terms of days of the week (or increasing on-site time); however, a minimum of 16 hours per week must be maintained. The IPA must provide IEHP with advance written notice of changes to the schedule.

d. IEHP Provider Relations or IEHP Quality Management team will confirm that the PCP is present according to the schedule by conducting telephone or unannounced in-person visits.

F. PCPs that voluntarily terminate their contract with IEHP may reapply if there are no quality issues involved.

G. If there is a change in ownership of an existing provider site, the site will need to undergo an initial site review.

H. PCPs denied participation or who have been removed twice from IEHP for any reason related to quality or compliance, are not allowed to reapply for participation with IEHP.

I. IEHP reserves the right to add additional requirements or perform specific additional monitoring as determined by IEHP.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	June 1, 2007	
Revision Effective Date:	January 1, 2024	

6. FACILITY SITE REVIEW

D. Residency Teaching Clinics

APPLIES TO:

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

POLICY:

A. All attending Physicians providing services to Members at residency clinics, as described in this policy, must be credentialed and approved by IEHP or the IPA, and open for enrollment through IEHP.

DEFINITIONS:

A. Residency Teaching Clinic – Clinics that operate full-time (Monday through Friday, approximately 8:00am to 5:00pm) as sites for the training of residents in a primary care discipline from an accredited residency training program.

PROCEDURES:

A. Except in cases specifically approved by the IEHP Chief Medical Officer or designee, IEHP may only assign Members to attending Physicians at residency teaching clinics. Members are not assigned to resident physicians.

B. IEHP Members who receive primary care services at a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or Indian Health Facility (IHF) facilities are directly assigned to the clinic itself. See Policy 3E, "Primary Care Provider Assignment."

C. For attending Physicians to receive Member assignment as a Primary Care Provider (PCP), the following conditions must be met:

1. Residency teaching clinics must undergo and pass a Facility Site Review (FSR) and Medical Record Review (MRR) (See Policy 6A, "Facility Site Review and Medical Records Review Survey Requirements and Monitoring").

   a. The number of medical records reviewed depends on the number of Practitioners, and the following requirements apply to Practitioners on a shared medical record system:

Number of PCPs	# of Medical Records reviewed
One (1) to Three (3) PCPs	10 Records
Four (4) to Six (6) PCPs	20 Records
Seven (7) or more PCPs	30 Records

   b. Each attending Physician receives the same medical record score if they share medical records by specialty type as applicable.

2. The attending Physicians receiving Membership must be on-site a minimum of eight (8) hours per week.
3. There must always be an attending Physician available during clinic office hours.

D. The attending Physician shall serve in a supervisory capacity for residents, but the attending Physician need not examine every patient that is examined by a resident.

E. When possible, Members should be empaneled to one (1) resident physician to ensure continuity of care during the time of the physician's residency.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

6. FACILITY SITE REVIEW

E. Rural Health Clinics

APPLIES TO:

A. This policy applies to all IEHP Providers (PCPs and Specialists) who treat IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP ensures access to primary care through Rural Health Clinics for Members that reside in designated rural area.

DEFINITIONS:

A. Rural Health Clinic - a clinic located in a designated by the Department of Health Care Services (DHCS) as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental conditions and meets all other requirements.[1]

PROCEDURES:

A. For a Primary Care Provider (PCP) site to receive Member assignment as a rural health clinic, the following conditions must be met:[2]

   1. The clinic must be under the medical direction of a physician.
   2. The PCP must be available on-site a minimum of eight (8) hours per week.
   3. There must be a credentialed Advanced Practice Practitioner (APP) ((i.e., a Nurse Practitioner (NP) or Physician Assistant (PA), Certified Nurse Midwife (CNM)) or another credentialed PCP available on-site the remainder of the open clinic hours.
   4. The PCP must adhere to the appointment access standards, see Policy 9A, "Access Standards."
   5. Any APP seeing Members must be supervised by the Physician assigned to the Members and practice under specific protocols available at the clinic site and/or practice agreement available at the clinic site. See policy 6F, "Advanced Practice Practitioner Requirements."
   6. The PCP must be available during clinic hours to the APP via phone or pager and meet all after-hours access requirements.

B. At the discretion of IEHP Chief Medical Officer (CMO) or designee, NPs may be assigned membership if practicing in a designated rural area.

   1. Members are assigned to the rural health clinic, not the individual PCP practicing at the site, or the NP if so designated to act as the PCP. See Policy 18A1, "Primary Care Provider – IPA and Hospital Affiliations."

[1] Title 42 Code of Federal Regulations (CFR) § 491.2
[2] 42 CFR § 491.7

6. FACILITY SITE REVIEW

E. Rural Health Clinics

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2007	
Revision Effective Date:	January 1, 2024	

6. FACILITY SITE REVIEW

F. Advanced Practice Practitioner Requirements

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Advanced Practice Practitioners (APP).

POLICY:

A. IEHP ensures that the relationship between Advanced Practice Practitioners (APP) and their supervising physician is that of a shared and continuing responsibility to follow the progress of the Member in a manner which assures the APP's adherence to the limits of the specific professional practice established by law and regulations, while maximizing patient safety, health and well-being.[1]

DEFINITIONS:

A. Advanced Practice Practitioners (APP) –This includes Nurse Practitioners (NP), Physician Assistants (PAs), and Certified Nurse Midwives (CNMs) authorized to provide primary care under Physician supervision. These practitioners are otherwise known as non-physician medical practitioners or mid-level practitioners.

PROCEDURES:

General Requirements

A. The ratio of APP to the supervising Physician must not exceed the full-time equivalent (FTE) of one of the following:

1. Nurse Practitioners (NPs) 4:1 Physician
2. Physician Assistants (PAs) 4:1 Physician
3. Certified Nurse Midwives (CNMs) 4:1 Physician

Four (4) is the maximum number of APP to one (1) physician, in any combination of the above.

B. Each APP shall not exceed a full-time equivalent Provider-to-patient caseload of one (1) Provider per 1,000 patients.

C. A Primary Care Provider's (PCP) maximum enrollment may be increased if an APP is present at the site, see Policy 18A2, "Primary Care Provider - Enrollment Capacity."

D. APPs are not directly assigned Members and are not listed in the Provider Directory. At the discretion of the IEHP Chief Medical Officer or designee, NPs may be assigned Membership if practicing in a designated rural area. See Policy 6E, "Rural Health Clinics."

[1] Title 22, California Code of Regulations (CCR) § 51241

E. Requirements for APPs for licensure, education, training and experience must meet credentialing standards as set by the IPA and the health plan. See policies 5A1, "Credentialing and Recredentialing – Credential Standards – Credentialing Policies," and 25B1, "Delegation Oversight - Credentialing Standards – Credentialing Policies."

F. APPs must identify themselves in all aspects of care as a non-physician Practitioner and staff must not use the terminology "doctor" to refer to APPs.[2]

G. APPs that prescribe controlled substances must have a valid and current Drug Enforcement Agency (DEA) registration number.

Physician Assistants (PA)

A. PAs must be practicing at a credentialed site assigned to their supervising Physician and have an onsite, site-specific "Practice Agreement of Physician Assistant" signed by one or more physicians and surgeons, or a physician and surgeon, who is authorized to approve the practice agreement on behalf of the staff of the physicians and surgeons.[3] All PAs act as the agent of the supervising Physician with whom they have an agreement.[4] This agreement must define specific services identified in practice protocols or specifically authorized by the supervising Physician.[5,6]

1. Both the Physician and PA must attest to, date and sign the agreement.[7]
2. An original or copy must be readily accessible and available at all practice sites in which the PA works.
3. The agreement must be reviewed, dated and signed whenever any changes occur within the practice agreement.

B. The Practice Agreement may authorize a PA to provide or perform activities if there is documentation evidencing the activity was actually performed.[8] Activities include, but are not limited to:

1. Physical examinations, including interscholastic athletic program examinations.[9]
2. Order durable medical equipment (DME) and make arrangements with regard to home health services or personal care services, as applicable. For home health and/or personal care services, after consultation with the supervising Physician, the PA may approve, sign, modify or add to the plan of treatment or care;[10]

[2] 16 CCR § 1399.547
[3] California Business and Professions Code (Bus. & Prof. Code), § 3502
[4] 16 CCR § 1399.541
[5] 16 CCR § 1399.540
[6] CA Bus. & Prof. Code, § 3502
[7] 16 CCR § 1399.540
[8] CA Bus. & Prof. Code § 3502
[9] 16 CCR § 1399.541
[10] Ibid.

3. Routine visual screening, which includes non-invasive, non-pharmacological, simple testing for visual acuity, visual field defects, color blindness and depth perception.

C. The Practice Agreement is assessed during the Facility Site Review (FSR) process that is conducted at a minimum of every three (3) years. A Practice Agreement will be accepted if signed and validated within the past 12 months. Failure to maintain a current Practice Agreement may be grounds for disciplinary action by the Medical Board of California against a PA licensure.

D. All credentialed sites with a PA must have a current Practice Agreement with their supervising Physician in place and PAs must be practicing at a site assigned to their supervising Physician.

Nurse Practitioners (NP) and Certified Nurse Midwives (CNM)

A. NP/CNM's must be practicing at a site assigned to their supervising Physician.

B. The Medical Practice Act authorizes Physicians to diagnose mental and physical conditions, to use drugs in or upon human beings, to sever or penetrate the tissue of human beings and to use other methods in the treatment of diseases, injuries, deformities or other physical or mental conditions. The performance of any of these functions by a NP requires a standardized procedure.

C. All credentialed sites with a NP or CNM must have current on-site site-specific written standardized procedures for NPs and CNMs signed by the supervising Physician and NP and/or CNM.

D. The standardized procedures must include all 11 elements jointly required by the Medical Board of California and the Board of Registered Nursing.[11] Standardized procedures must also include book (specify edition) or article title, page numbers and sections, and other written sources. Additionally, the standards of care established by the sources must be reviewed and authorized by the Nurse Practitioner, Physician, and administrator (as appropriate) in the practice setting.[12]

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2007	
Revision Effective Date:	January 1, 2024	

[11] 16 CCR § 1474
[12] Ibid.

6. FACILITY SITE REVIEW

G. Urgent Care Center Evaluation

APPLIES TO:

A. This policy applies to contracted Urgent Care centers serving IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP conducts an evaluation of all Urgent Care centers to ensure their capacity to support the safe and effective provision of urgent care services.

PROCEDURES:

A. IEHP performs an evaluation on contracted Urgent Care centers initially and at a minimum of every three (3) years thereafter (See, "IEHP Urgent Care Evaluation Tool" found on the IEHP website[1]).

B. When an Urgent Care center would like to be contracted with IEHP they are required to undergo the Medical Record Review (MRR) and an Urgent Care Center Evaluation. Five (5) medical records are evaluated against the IEHP Urgent Care Guidelines (See, "IEHP Urgent Care Center Evaluation Tool" found on the IEHP website[2]) where all the following minimum requirements must be met:

1. Physician is credentialed in accordance with IEHP's credentialing and re-credentialing guidelines. Physician must be Board-certified or eligible in the following specialties and/or subspecialties: Family Practice, Internal Medicine, Pediatrics, or Emergency Medicine. If the Provider does not have the above training qualifications, they will be subject to review for approval by IEHP's Credentialing Subcommittee.
2. If the Urgent Care also functions as a Primary Care Provider (PCP) site, hours may **not** be combined to meet the 16 hour requirement for PCP sites. Physicians or Non-Physicians Medical Practitioners (NPMP) are required to be onsite during hours of operation.
3. Urgent Care centers must maintain coverage for Members of all ages and genders during hours of operation, except for "pediatric only" Urgent Care centers, which must maintain coverage for Members of all genders and ages under 21 years old.
4. Triage and/or telephone advice is performed by appropriate licensed personnel: Doctor of Medicine (MD)/ Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), Physician Assistant (PA) or Registered Nurse (RN). Licensed Vocational Nurses (LVNs) and non-licensed staff are not allowed to perform triage and/or provide telephone advice.
5. Laboratory Services: Urgent Care centers must maintain a current and valid California Laboratory Improvement Amendment (CLIA) waiver/certificate specific to the site

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

location.[3] Members must have immediate access to a laboratory on-site, with ability to perform all laboratory tests specified below as waived by CLIA and results available to the Member and PCP:

a. Urine human chorionic gonadotropin (HCG);

b. Hemoglobin or Hematocrit (*Note – an off-site laboratory that can provide stat H & H results within 1-hour is acceptable);

c. Blood Glucose;

d. Urine Dipstick;

e. Rapid Strep; and

f. Sexually Transmitted Infections (STI) collection materials.

6. Radiology Services: Urgent Care centers must maintain on-site or immediate access to diagnostic radiology services (plain film x-rays) with urgent results made available to Member and PCP. Urgent Care centers must demonstrate the ability to perform chest and limb x-rays at minimum.

7. Language Services: Members must have access to oral interpretation services, at no cost to the Member. Oral interpretation must be provided in all languages and is not limited to threshold or concentration standard languages. Interpretation can occur through the following language services;

   a. Telephonic: IEHP provides 24/7 access to telephonic interpreter services to Members and Providers. Members and Providers may contact Member Services at (800) 440877) 273-IEHP (4347) during business hours for these services. After business hours, Members and Providers can call the 24-Hours Nurse Advice Line at (888) 244-IEHP (4347) to access interpreter services.

   b. Video Remote Interpreting (American Sign Language (ASL) Only): IEHP provides 24/7 access to Video Remote Interpreting (VRI) services to Members and Providers. For set up and technical assistance, contact IEHP Provider Relations Team at (909) 890-2054. The Urgent Care center is responsible for the cost, maintenance, and connectivity (Wi-Fi, Cellular, LAN) of IEHP- approved VRI equipment.

8. Equipment: Members must always have access to the following equipment on site:

   a. Electrocardiogram (EKG) machine;

   b. Nebulizer;

   c. Splinting materials;

   d. Wound irrigation supplies;

[3] Title 42 of the Code of Federal Regulation (CFR) §493.37

e. Eye and ear irrigation supplies;

f. Eye Tray;

g. Eye chart literate/illiterate and occluder for vision testing;

h. Suture kits and materials;

i. Dressing supplies;

j. Suction machine and catheters (Recommended);

k. Nasogastric (NG) tubes (Recommended);

l. Wood's Lamp (Recommended);

m. Oxygen;

n. Pulse Oximetry.

o. Ophthalmoscope;

p. Otoscope, and adult and pediatric ear speculums;

q. Basic exam equipment: percussion hammer, tongue blades, patient gowns;

r. Scales: standing and infant scales;

s. Thermometers: oral and/or tympanic/Thermoscan with a numeric reading;

t. Stethoscope and sphygmomanometer with various size cuffs (e.g. child, adult, obese/thigh); and

u. Exam table and lights in proper working order.

9. Medication: Providers must always have access to the following medication on- site:

a. Albuterol for inhalation;

b. Epinephrine 1:1,000 for anaphylaxis;

c. Benadryl Intramuscular (IM) or Per Oral (PO);

d. Burn Dressing;

e. Tylenol and Motrin;

f. Anti-nausea;

g. Anti-diarrhea;

h. Injectable Antibiotics;

i. Tdap (Tetanus, Diphtheria, Pertussis);

j. Xylocaine; and

k. Fluorescein Strips.

10. Urgent Care centers must have an emergency transport policy/action plan.
11. Minimum Hours of Operation: Monday through Friday, 5 p.m. to 8 p.m. The Urgent Care center must be open at least four (4) hours on Saturday, Sunday and the major holidays listed below:
    a. New Year's Day;
    b. Memorial Day;
    c. 4th of July;
    d. Labor Day;
    e. Thanksgiving Day; and
    f. Christmas Day.
12. An Advanced Practice Practitioner (APP) (Nurse Practitioner or Physician Assistant) that evaluates Members during their visit at the Urgent Care center, when the Physician is not physically on site, is expected to practice only under specific and clearly written protocols approved by the supervising Physician.
    a. The supervising Physician providing the oversight and their APP must be credentialed and/or recredentialed according to IEHP standards.
    b. The supervising Physician must be able to display evidence of oversight through 10% medical record review of the APP within 30 days of the visit.
    c. Supervising physician specialty must cover the population served.

C. These eight (8) critical elements, related to the potential for adverse effect on patient health or safety, have a scored "weight" of two (2) points. All other survey criteria are weighted at one (1) point.

1. Language services: Members must always have access to Telephonic and Video Remote Interpreting (ASL only);
2. Only qualified/trained personnel retrieve, prepare or administer medications;
3. Oxygen: Oxygen tank must be a minimum of ¾ full;
4. Appropriate sizes of Engineered Sharps Injury Protection (ESIP) needles/syringes;
5. Personal Protective Equipment (PPE) is readily available for staff use;
6. Needlestick safety precautions are practiced on site;
7. Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling processing, storage, transport, or shipping; and
8. Spore testing of autoclave/steam sterilizer with documented results (at least monthly).

D. Compliance level categories for the Urgent Care center evaluation are as follows:

1. Exempted Pass — 90% and above (without critical element deficiencies, or deficiencies in required medications and/or infection control)
2. Conditional Pass — 80-89% or 90% and above (with critical element deficiencies, or deficiencies in required medications and/or infection control)
3. Not- Pass — Below 80%

E. Urgent Care centers must receive a score of 80% or greater on the "IEHP Urgent Care Center Evaluation Tool" without any critical element deficiencies. Audits which score less than 90% collectively or less than 80% on any one section will require a Corrective Action Plan (CAP). Assignment of "Urgent Care" status will not be given until the CAP process is complete.

F. Corrective Action Plan (CAP) process

1. The CAP process addresses deficiencies found during the evaluation and provides guidance for the Urgent Care center to bring their facility into full compliance with IEHP standards.
2. The Urgent Care center receives a CAP notification letter at the time the evaluation is performed. Any deficiencies found during the evaluation are noted on the form. The CAP letter notes the timeframes for corrective action, and any other pertinent information.
3. The Urgent Care center must address all critical element deficiencies by submitting a CAP to IEHP within 10 working days of the evaluation date.
4. IEHP will verify correction of critical element deficiencies within 30 business days of the evaluation date.
5. All Urgent Care centers are responsible for developing and submitting their non-critical element CAPs to IEHP within 30 calendar days of the evaluation date.
6. IEHP has 30 calendar days to review and accept the CAP and complete a CAP verification site visit (as needed).
7. If the site continues to have deficiencies at the time of verification, an additional 30 calendar days will be allowed for the Urgent Care center to address all issues and IEHP to review and accept the CAP and perform a CAP verification site visit if needed.

G. CAP Verification Process

1. Once it has been demonstrated that a site has met IEHP's threshold of Conditional Pass and a CAP has been accepted and verified, no further follow-up is required. However, further monitoring may be done at IEHP's discretion.
2. IEHP verifies the Urgent Care center's continued compliance for implementing the submitted CAPs as follows:

a. At the Certified Site Reviewer's (CSR) discretion, a desk review of evidence of CAP; or

b. An onsite or virtual CAP verification.

3. All Urgent Care centers that receive a non-passing score (below 80%), does not submit a CAP, or does not address deficiencies will be presented to the IEHP Peer Review Subcommittee for further review and action(s) taken as appropriate.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2017	
Revision Effective Date:	January 1, 2024	

6. FACILITY SITE REVIEW

H. Interim FSR Monitoring for Primary Care Providers

APPLIES TO:

A. This policy applies to all Primary Care Providers (PCPs), who provide care and services to IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP conducts Interim Facility Site Reviews (FSR) and Medical Record Reviews (MRR) to monitor PCPs between site reviews to investigate problems identified through monitoring activities or follow-up on corrective actions.

PROCEDURES:

A. A PCP Interim FSR is conducted between the initial and periodic FSR and MRR surveys, between 16 and 20 months from the previous FSR and MRR surveys and is required at least once between the three (3) year review cycle.

B. The Interim FSR evaluates the following: 14 critical elements, after- hours PCP access and emergency care instructions/telephone information made available to patients, the Initial Health Assessment (IHA), and/or any criteria on the DHCS FSR and MRR tool (See, "Interim Facility Site Review (Self-Assessment) Tool" found on the IEHP website).[1]

1. Interim FSR (Self-Assessment)
    a. PCP sites will complete the Interim FSR (Self-Assessment) if they have scored 90% or above in their previous FSR & MRR survey.
    b. PCPs must submit their completed self-assessment via fax at (909) 890-5746 to IEHP Quality Management Department QM Coordinators with a signature of attestation within 10 business days of receiving assessment.
2. Interim FSR (On-Site)
    a. An Interim FSR (On-Site/virtual) will be performed if the PCP site scored below 90% in their previous FSR & MRR survey
    b. At the discretion of the health plan and Certified Site Reviewer (CSR), an interim self-assessment may be converted into an interim on-site review.
3. For all onsite/virtual Interim reviews, IEHP will conduct an interim onsite/virtual MRR on a minimum of five (5) or available charts during the interim FSR.

C. Corrective Action Plan (CAP)

1. PCP offices with identified deficiencies as a result of the Interim FSR (Self-Review form or On-Site/virtual) will be issued a request for CAP (See, "Corrective Action Plan

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

Notification Tool" found on the IEHP website).[2] The CAP must be completed within the timeframes as discussed in policy 6A, "Facility Site Review and Medical Record Review Survey Requirements and Monitoring."

2. If the answer is "No" to any of the 14 critical elements, a CAP will be issued and the PCP must submit a completed CAP to IEHP within 10 calendar days of CAP request.

D. Monitoring and Oversight

1. IEHP systematically monitors all PCP sites between each regularly scheduled FSR and MRR Survey. Monitoring sites between audits includes internal quality management systems, and external sources of information.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2016	
Revision Effective Date:	January 1, 2024	

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

6. FACILITY SITE REVIEW

I. Behavioral Health Hospital Survey

APPLIES TO:

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

POLICY:

A. IEHP conducts its Behavioral Health (BH) Hospital Survey on all contracted inpatient psychiatric Hospitals to ensure their capacity to support safe and effective provision of services.

PROCEDURES:

Behavioral Health Hospital Survey

A. IEHP utilizes the BH Hospital Survey Tool, as approved by the IEHP Quality Management (QM) Committee, to verify compliance with the following review criteria and assign scoring appropriately (See, "Behavioral Health Hospital Survey Tool" found on the IEHP website).[1]
   1. Policies & Procedures Criteria
   2. Format Criteria
   3. Documentation Criteria
   4. Initial Assessment Criteria
   5. Treatment Planning Criteria
   6. Progress Notes Criteria
   7. Medication Management Criteria
   8. Coordination of Care Criteria
   9. Discharge and/or Transfer Criteria

B. Critical elements related to the potential for adverse effect on patient health or safety have a scored "weight" of two (2) points. All other survey criteria are weighted at one (1) point.

Initial and Ongoing BH Hospital Survey

A. IEHP schedules the BH Hospital Survey directly with the inpatient psychiatric Hospital to take place within 12 months of the inpatient psychiatric Hospital's initial or renewed IEHP contract effective date and every three (3) years, thereafter.

B. Inpatient psychiatric Hospitals where documentation of patient care by multiple physician reviewers occurs in the same record are reviewed as a "shared" medical record system. Shared

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

medical records are considered those that are not identifiable as "separate" records belonging to any specific physician reviewer.

C. Utilizing the BH Hospital Survey Tool, IEHP reviews up to 10 randomly selected medical records. During the BH Hospital Survey, IEHP, at its discretion, may request additional medical records to review.

D. Categories for the BH survey score results are as follows:

1. The BH Hospital Survey contains a total of 101 points, with the following compliance level categories:

Exempted Pass	Conditional Pass	Fail (Not Pass)
• 90% and above without deficiencies in critical elements • CAP not required	• 90% and above with deficiencies in critical elements • 80% and above • CAP required	• 79% or below • CAP required

2. Full points are given if the scored element meets the applicable criteria. Partial points are not given for any scored element that is considered only "partially" met. Zero (0) points are given if an element does not meet all criteria.

E. Inpatient psychiatric Hospitals that receive an Exempted Pass are not required to complete a Corrective Action Plan (CAP) unless determined necessary by IEHP.

F. CAP is required of inpatient psychiatric Hospitals in these scenarios to address 100% of cited deficiencies within 30 calendar days of the survey date:

1. The Hospital receives a Conditional Pass; i.e., a score of 80-89% or 90% and above with one or more sections scoring below 80%; or
2. The Hospital receives a BH Hospital Survey score of 79% or below; or
3. The Hospital reveals significant quality of care issues during the BH survey.

G. An inpatient psychiatric Hospital that scores 79% or below on the BH Hospital Survey is considered a "failed site".

1. Failed sites will receive a CAP notification and must score a minimum of 80% on their next annual BH Hospital Survey.
2. IEHP reserves the right to take any or all of these actions against failed sites or those inpatient psychiatric hospitals that reveal significant quality of care issues during the BH survey.
   a. Issue a request for CAP to correct identified deficiencies; and/or
   b. Place the inpatient psychiatric Hospital on an annual review; and/or

c. Hold any new referral or transfer of Members until CAP is received, verified and closed; and/or

d. Escalate the issue to IEHP's Peer Review Subcommittee or designee for further action; and/or

e. Terminate the inpatient psychiatric Hospital from IEHP's network. If termination occurs, IEHP will notify County Behavioral Health.

Focused BH Hospital Survey

A. At the discretion of IEHP's Chief Medical Officer or designee, IEHP can perform a focused BH Hospital Survey on any inpatient psychiatric Hospital contracted with IEHP, with or without prior notification.

B. A focused survey is an audit used to investigate specific issues identified through quality monitoring, Member complaints, Potential Quality Incident (PQI), referral from other internal departments, or to follow up on corrective actions. All deficiencies found in a focused survey require the completion and verification of a CAP according to established CAP timelines.

C. Inpatient psychiatric hospitals that receive a Potential Quality Incident (PQI) and has had a minimum of three (3) substantiated Member complaints related to facility issues or record keeping will be surveyed within 90 days of the third complaint or PQI.

1. If the inpatient psychiatric Hospital passes the review criteria, then the site will resume the regular scheduled audit timeframe (See, "Behavioral Health Hospital Survey Tool" found on the IEHP website).[2]

2. If the inpatient psychiatric Hospital does not pass the review criteria, it will be required to complete a CAP and be monitored every six (6) months until deficiencies are resolved. Monitoring will be done by reviewing Member complaints and/or through additional focused surveys.

D. IEHP may, at its discretion, add an addendum to the BH Hospital Survey to perform a focused audit.

Corrective Action Plan

A. IEHP issues a CAP notification letter at the time the BH Hospital Survey is performed. The CAP notification letter notes the inpatient psychiatric hospital's status, deficiencies found during the BH Hospital Survey, timeframes for corrective action, and any other pertinent information (See, "BH Hospital Survey – Corrective Action Plan Tool" found on the IEHP website).[3]

1. CAPs for critical elements are given at the time of survey.

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

2. CAPs for all non-critical element deficiencies are issued within 10 calendar days of survey completion.

B. Inpatient psychiatric Hospitals, wishing to appeal the results of their BH Hospital Survey must do so by writing to the IEHP Chief Medical Officer or designee within 14 business days of the date of the CAP notification.

1. Within 30 days of receiving a written appeal, the IEHP Chief Medical Officer or designee responds in writing to the appealing inpatient psychiatric Hospital noting the status of the appeal.

2. If the appeal in whole or in part is not accepted by IEHP, the inpatient psychiatric hospital has 30 calendar days to submit a CAP addressing all deficiencies noted in the BH Hospital Survey.

C. If deficiencies are found in any of the critical elements, the inpatient psychiatric Hospital must submit a CAP and evidence of corrections within 10 calendar days of the survey date.

D. Inpatient psychiatric hospitals that do not correct survey deficiencies within the established CAP timelines will not receive any new referrals or Member transfers until corrections are verified and the CAP is closed.

E. Any inpatient psychiatric Hospital that does not come into compliance with the review criteria within the established timelines may be referred to IEHP's Chief Medical Officer or designee for further action, including up to termination of the Hospital from IEHP's network.

CAP Verification Process

A. IEHP must perform its CAP verification within 30 calendar days of receiving the inpatient psychiatric Hospital's CAP.

B. At IEHP's discretion, CAPs for critical or non-critical elements may be verified onsite or via document submission.

C. If a verification results in the identification of additional deficiencies, IEHP will require an additional CAP within the same CAP timeframes described above. A second CAP verification is therefore, performed within 30 calendar days of accepting the second CAP.

D. Once IEHP verifies that the inpatient psychiatric Hospital has met IEHP's threshold of Conditional Pass and a CAP has been accepted and verified, no further follow-up is required. IEHP may however, continue monitoring the hospital at its discretion.

Monitoring

A. IEHP systematically monitors all psychiatric Hospitals between each regularly scheduled BH Hospital Survey. Monitoring sites between surveys include the use of both internal quality management systems and external sources of information, such as focused surveys, PQI referrals, and/or review of Member complaints. All deficiencies identified through the monitoring process require the completion of a CAP according to CAP timelines.

B. Information from BH Hospital Surveys are reported to the Quality Management Committee.

6. FACILITY SITE REVIEW

I. Behavioral Health Hospital Survey

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☒ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2021	
Revision Effective Date:	January 1, 2024	