14. UTILIZATION MANAGEMENT

A. Delegation and Monitoring

APPLIES TO:

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

POLICY:

A. IEHP delegates utilization management activities related to medical services for assigned Members to its Delegates.[1]

B. 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.

C. IEHP maintains responsibility of ensuring that its Delegates comply with all applicable State and federal laws and other requirements set forth by the Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and IEHP.[2]

D. Authorization and financial responsibilities are delineated in the Division of Financial Responsibilities (DOFR).

PURPOSE:

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

DEFINITION:

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

PROCEDURES:

UM Program Requirements

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

   1. Mission statement, goals, and objectives;

   2. Program structure, which includes at minimum:

[1] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.3

[2] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.3

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;

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;[3]

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:

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] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.2

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]

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;

d. Monitoring documentation for adequacy;

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

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. 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:

a. UM Technicians/Coordinators – eligibility determination, editing of referral form for completeness, interface with Provider offices to obtain any needed non-medical information,[7] and approval of authorizations as determined appropriate (auto authorizations). 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, obtaining additional medical information,[8] as needed, from the Provider's offices, approval of referrals based on IEHP-approved

[4] California Health and Safety Code (Health & Saf. Code) §1367.01
[5] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.2
[6] Title 22, California Code of Regulations (CCR) § 53857
[7] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.6
[8] Ibid.

authorization criteria, concurrent inpatient, and initiate denials for non-covered benefits and carve outs.

c. Registered Nurses (RN) – initial review of medical information, initial determination of benefit coverage, obtaining additional medical information as needed, from the Provider's office,[9] 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.[10] The organization determination must be reviewed by a physician or other appropriate health care professional with expertise in the field of medicine or health care that is appropriate for the service at issue, including knowledge of Medicare coverage criteria, before the organization determination decision is issued.

4. **Use of Board-Certified Physicians for UM Decisions:** Delegates must have a written policy and procedure demonstrating their use of designated physicians with current unrestricted license for UM decisions.

   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. Criteria sets approved by IEHP include CMS Local Coverage Determination, Local Coverage Articles and National Coverage Determination, Milliman Care Guidelines, InterQual, Apollo Managed Care Guidelines/Medical Review Criteria, World Professional Association for Transgender Health standards of care, and IEHP UM Subcommittee-Approved Authorization Guidelines.[11] IEHP may distribute additional criteria following

[9] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.6
[10] Ibid.
[11] CA Health & Saf. Code § 1363.5(b)

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. IEHP ensures these criteria are consistent with sound clinical principles and processes and are evaluated at least annually and updated if necessary. [12]

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. Decisions to deny services cannot be solely based on codes being listed as non-covered, i.e. Medi-Cal Treatment Authorization Request (TAR) and Non-Benefit list of codes. 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:

   a. Availability of 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 or home care, Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS), Managed Long-Term Services and Support (MLTSS), Multipurpose Senior Services Program (MSSP), or Behavioral Health; and

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

   Delegates must ensure consistent application of UM criteria by following this specific order as the Delegate is licensed to use:

   a. IEHP Member Handbook (Evidence of Coverage); **then**

   b. Local Coverage Determination (LCD); **then**

   c. Local Coverage Article (LCA); **then**

   d. National Coverage Determination (NCD); **then**

   e. Medicare Benefit Policy Manual; **then**

   f. World Professional Association for Transgender Health standards of care; **then**

[12] CA Health & Saf. Code §1363.5

g. National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium **or** IBM Watson Health Products: Micromedex; **then**

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

i. InterQual Criteria; **then**

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

k. IEHP Utilization Management (UM) Subcommittee Approved Authorization Guidelines **or** Pharmacy and Therapeutics (P&T) Subcommittee Approved Prior Authorization Criteria.

3. **Annual Review and Adoption of Criteria:** IEHP develops and/or presents criteria to the IEHP UM Subcommittee for adoption and implementation. Delegates 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 Delegates and 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.

4. **Process for Obtaining Criteria:** Delegates must disclose to Providers, Members, Members' representative or the public, upon request, the clinical guidelines or criteria used for determining health care services specific to the procedure or condition requested.[13]

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

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

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

   Coverage decision letters must state the address and phone number to call for obtaining the utilization criteria or benefits provision used in the decision. 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[14]). [15] Delegates must maintain a log of all requests for criteria (See, "Request for UM Criteria Log" found on the IEHP website[16]).

5. **Annual Assessment of Consistency of UM Decisions (Inter-rater Reliability):** Delegates are responsible for evaluating, at least annually, the consistency with which healthcare professionals involved in utilization review apply appropriate criteria for

[13] CA Health & Saf. Code §1363.5
[14] https://www.iehp.org/en/providers/provider-resources?target=forms
[15] CA Health & Saf. Code §1363.5
[16] https://www.iehp.org/en/providers/provider-resources?target=forms

decision-making. Delegates must act on identified opportunities to improve consistency. The sample assessed must be statistically valid, or Delegates may use one (1) of the following three (3) auditing methods:

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

b. NCQA 8/30 methodology; or

c. Ten (10) hypothetical cases.

Review of UM Data

A. Delegates must collect, report, and analyze UM data related to Members for potential over or under utilization.

1. UM data 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 physicians for both over-utilization and under-utilization.

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 the provision of health care services for Members. These policies and procedures must be available to the public upon request.[17]

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.

[17] 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.

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, and to ensure coordination of medically necessary care from the non-network specialist. 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.

   When an outpatient or inpatient service requested appears to be unavailable within the IEHP network and IEHP is responsible for paying for the facility charges, the Delegate must review the request to determine if the request meets criteria. Once the Delegate determines that criteria is met, the clinical information must be sent to IEHP to make the final decision. If IEHP determines the requested service cannot be provided within its network, IEHP will initiate the Letter of Agreement (LOA) process. It is therefore critical that the Delegate submit the referral with all supporting documentation as soon as possible to the Plan via the secure IEHP Provider Portal to prevent delay in care. If the request can be handled within the network or does not meet the criteria, the Delegate can modify or deny as appropriate.

4. **Prior Authorization Requirements:** Delegates must maintain a list of services that require prior authorization or have a list of services that do not require prior authorization like below, at minimum:

   a. The prior authorization 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 14C, "Emergency Services");[18,]

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

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

      4) Sexually Transmitted Infection (STI) services (See Policy 10G, "Sexually Transmitted Infection (STI) Services");

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

      6) HIV testing and counseling (See Policy 10H, HIV Testing and Counseling");

      7) Immunizations;

[18] Medicare Managed Care Manual, "Chapter 4 - Benefits and Beneficiary Protections," §20.3

8) Routine OB/GYN services, including prenatal care by Family Care Practitioner (credentialed for obstetrics) within the IPA's network;

9) Out of area renal dialysis;[19]

10) Biomarker testing for advanced or metastatic stage 3 or 4 cancers;[20]

- 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.[21]

11) Urgent Care

12) Preventive services; and

13) Other services as specified by CMS.

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

c. 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:

a. Employ IEHP-approved UM authorization guidelines, as outlined in this policy, and make medical necessity determinations based on all of the following:

1) Coverage and benefit criteria as specified at § 422.101(b) and (c) and may not deny coverage for basic benefits based on coverage criteria not specified in § 422.101(b) or (c).

2) Whether the provision of items or services is reasonable and necessary under section 1862(a)(1) of the Act.

3) The enrollee's medical history (for example, diagnoses, conditions, functional status), physician recommendations, and clinical notes.

4) Where appropriate, involvement of the organization's medical director as required at § 422.562(a)(4).

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

[19] Medicare Managed Care Manual "Chapter 4 - Benefits and Beneficiary Protections" §110.1.3
[20] California Health and Safety Code (CA HSC) §1367.665
[21] https://www.accessdata.fda.gov/scripts/cder/daf/

by a Medical Director. The request for additional information must be annotated and include the date of request.[22]

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.

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. For Members with Dual coverage, the primary insurance will determine the decision timeframe (see, "UM Timeliness Standards – IEHP DualChoice" found on the IEHP website[23]).

a. The prior authorization process is initiated when the Member, Member's representative, or the Member's Physician requests a referral or authorization for a procedure or service. The timeframe begins upon receipt of the request. Please see policy 14A1, "Review Procedures – Primary Care Provider Referrals" for more information

b. Delegate will identify upon intake any prior authorization request in which IEHP is responsible for making a determination (including requests for behavioral health, optometry and general anesthesia for routine dental requests) and will ensure these requests are forwarded to IEHP within one (1) business day of receipt by forwarding the request to the Plan through the secure IEHP Provider Portal.

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.[24]

d. *Prior Authorization for Expedited Initial Organization Determinations (EIOD) and Urgent Concurrent:*[25] Delegates are required to perform Expedited Initial Organization Determinations (EIOD) for service authorization requests where the Provider indicates or the Delegate determines that following the standard timeframe could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.[26] The following requests should be classified as

[22] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.6
[23] https://www.iehp.org/en/providers/provider-resources?target=forms
[24] CA Health & Saf. Code § 1367.01
[25] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 40.8
[26] Ibid.

concurrent: Continued Home Health, Physical Therapy (PT), Speech Therapy (ST), Occupational Therapy (OT) and Durable Medical Equipment (DME) when the original preservice authorization has not expired. Please see Policy 14I, "Expedited Initial Organization Determination" for more information.

e. *Post-Service Organization Determinations (Retrospective Review):* Services that require prior authorization but are rendered without such authorization must 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, the Delegate 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. If medical necessity is not met, denial determinations must be made by the Delegate Medical Director. Both the Member and Provider must be notified of post-service (retrospective review) determinations.

f. The timeframes for rendering decisions and sending notifications to the Member and Provider are outlined in this Provider Manual (See, "UM Timeliness Standards – IEHP DualChoice" found on the IEHP website[27]).

7. **Experimental and Investigational Determinations:** The determination for all experimental and investigational services is the responsibility of IEHP.

a. The Delegate must send to IEHP all authorization requests for experimental/investigational services as soon as possible after receipt. This must be sent via the secure IEHP Provider Portal. The request must include all supporting clinical information including diagnosis (ICD) and procedure (CPT) codes.

b. The Milliman Care Guidelines (MCG) term "role remains uncertain" does not indicate that a request is considered experimental/investigational. The Delegate must review these requests utilizing the next criteria set in the hierarchy. If there are no other criteria to review, the Delegate must forward the request to IEHP as outlined above.

c. IEHP is responsible for decision-making and notifying the Provider, Member and Delegate of the determination, per standard timeframes for level of urgency.

8. **Out-of-Network/Capitated Providers**: Prior to redirecting a referral from an out-of-network provider to a contracted or capitated Provider, the Delegate must first verify and document the following:

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

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.

9. **Denial Notices**: 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.[28] Members and Providers must receive denial letters for any requested referral that is denied or modified.[29]

   a. 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. Denial notices must adhere to the following:

      1) Include required CMS language;

      2) Be typed in 12-point font and written in a manner, format, and language that can be easily understood;[30]

      3) Be made available in IEHP Threshold Languages;

      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;[31]

      5) Sixth (6th) grade level language appropriate for the Member population describing the reason for the denial;

[28] CA Health & Saf. Code § 1367.01
[29] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 40.12.1
[30] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.4
[31] Ibid.

- Medical necessity denials must cite the criteria used and the reason why the clinical information did not meet criteria; [32,33]
- Non-covered benefit denials must cite the specific provision in the Evidence of Coverage (EOC) (i.e., the IEHP Member Handbook), CMS guideline (LCD, LCA, NCD, or Medicare Benefit Policy Manual) or State/Federal regulations that excludes that coverage.

6) Information for the Member regarding alternative treatment and direction for follow-up care; and

7) Information on how to file an oral or written expedited grievance, file a standard or fast appeal, or file an immediate review or appeal as applicable.[34]

The Delegate must have in place Quality Assurance (QA) procedures to monitor the items listed above and check for deficiencies in the medical rationale for the denial, the clarity of the language and the inclusion of correct information in the letter.

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.[35] This communication must offer the requesting Provider the opportunity to discuss any issues or concerns regarding the decision. This written notification of denial or partial approvals (modifications) must include language informing the Provider of the appeal process. 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 Universes (See "IEHP Universe Standard Auth MSSAR Template" and "IEHP Universe Expedited Auth MESAR Template" found on the IEHP website[36]);

2) Letters and attachments;

3) Clinical documentation;

4) Referral;

5) Outreach/call logs, if any

6) Supporting evidence of the following:

[32] CA Health & Saf. Code § 1367.01
[33] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 40.12.1
[34] Ibid.
[35] CA Health & Saf. Code § 1367.01
[36] https://www.iehp.org/en/providers/provider-resources?target=forms

- 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.

d. For Delegates responsible for Medicare benefit only:

1) If a service request is not a covered benefit under Medicare, but is a covered benefit under Medi-Cal, no Medicare denial letter is needed prior to forwarding to Health Plan (see "Medicare Non-Covered Services" found on the IEHP website[37]).IEHP is responsible for making the determination. As such, the Delegate shall forward these requests to the Plan through the secure IEHP Provider Portal.

Other UM Program Requirements

A. **Referral Requests:** PCPs are responsible for supervising, coordinating, and providing initial primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. 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:** Delegates 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 12A5, "Coordination of Care – Continuity of Care."[38]

C. **Standing Referrals:** Delegates 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 a specialty care center for a Member who has a life threatening, degenerative, or disabling condition that requires coordination of care by a Specialist. IEHP and its Delegates must have a system in place to track open, unused; and standing referrals.[39] For more information, please see Policy 14A2, "Standing Referral/Extended Access to Specialty Care " for more information.

[37] https://www.iehp.org/en/providers/provider-resources?target=forms
[38] Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide, Section V, Medicare Continuity of Care Guidance for All D-SNPs
[39] CA Health & Saf. Code § 1374.16

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. Refer to Policy 14B, "Second Opinions" for more information.

E. **Behavioral Health:** Behavioral Health benefits for IEHP DualChoice Members are obtained through the IEHP Behavioral Health Program.

F. **Vision Services:** Vision is not a Medicare benefit unless specifically for covered lenses post cataract surgery. IEHP DualChoice Members may have additional limited benefits through Medi-Cal.

G. **Pharmacy Services:** Please refer to the Division of Financial Responsibility (DOFR) in your contract regarding pharmacy services.

H. **Supplemental Benefits:** Supplemental benefits may vary and are the responsibility of the Health Plan. Please refer to IEHP's website for a list of current benefits.

I. **Communication Services**: 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:

1. Delegate shall maintain telephone access for Providers to request authorization for healthcare services.[40]
2. Delegate 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. Communications received after normal business hours will be returned on the next business day.
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.
5. Staff can receive inbound communication regarding UM issues after normal business hours.
6. There is a toll-free TDD/TTY services for Members who are deaf, hard-of-hearing, or speech impaired.
7. Language assistance is available for IEHP Members to discuss UM issues.

J. **Rescinding or Modifying Authorization** - Any authorization provided by IEHP or its Delegate must not be rescinded or modified after the Provider has already rendered the health care service in good faith pursuant to the authorization.[41]

[40] CA Health & Saf. Code § 1367.01
[41] CA Health & Saf. Code § 1371.8

K. **Record Retention:** Delegates shall retain information on decisions, i.e., authorizations, denials or partial approvals (modifications) for a minimum period of ten (10) years.[42]

L. **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.

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, 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.

3. **Documentation:** Delegates must have procedures 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 the 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.[43]

M. **Inpatient Stay**: The utilization management process must include:

1. Determining medical necessity.

2. Determining appropriate level of care.

3. Coordinating with hospital Case Manager's discharge plan.

[42] Title 42 Code of Federal Regulations (CFR) §422.504(b)
[43] 42 CFR § 438.404(b)(2)

Please see Policy 14G, "Acute Admission and Concurrent Review" for more information.

N. **Discharge Planning:** The UM process must include the following activities related to discharge planning: [44]

1. Determining level of care (SNF, office visit, home health, home without services);
2. Arranging necessary follow-up care (home health, follow-up PCP or specialty visits, etc); and
3. Facilitating transfer of the discharge summary and/or medical records, as necessary, to the PCP office.

Please see Policy 14G, "Acute Admission and Concurrent Review" for more information.

O. **Repatriation:** IEHP and its Delegates must assist with the transfer of Members, as medically appropriate, back into the IEHP network.

P. **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.

Q. **Confidentiality:** IEHP recognizes that Members' confidentiality and privacy are protected. It is the policy of IEHP and 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.

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

S. **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

[44] Medicare Managed Care Manual, "Chapter 17 – Subchapter F: Benefits and Beneficiary Protections." §120.6 – Continuity of Care

this evaluation and ensure that decisions are rendered, unhindered by fiscal and administrative management.[45]

T. **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 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:[46]

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 of Delegate

A. IEHP monitors and oversees delegated UM activities performed by the Delegates.[47] 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 and 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 denial and approval universes and letters, Readmissions, quarterly and annual work plan. Provider reports and utilization data is subsequently reviewed by the Delegation Oversight Committee (DOC).
3. **Review of SARAG Approval and Denial Universe Pre-Service Reports and Letters** – IEHP and its Delegates are required to submit a monthly Referral Universe from which

[45] CA Health & Saf. Code § 1367.02
[46] CA Health & Saf. Code § 1367.01(e)
[47] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.3

authorizations are selected for review. Please refer to Policy 25E2, "Utilization Management – Reporting Requirements" for more information.

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 Practitioner Grievance Review** – IEHP performs review, tracking, and trending of Member or Practitioner 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. JOMs are held with Hospitals and Delegates to address specific Provider Experience, UM, QM, CM, grievance, study results, or any other pertinent quality issues. 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.

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14. UTILIZATION MANAGEMENT

A. Review Procedures

1. Primary Care Provider Referrals

APPLIES TO:

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

POLICY:

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

B. IEHP and its Delegates must have a referral system to track and monitor referrals requiring prior authorization through the program of Utilization Management program oversight. See Policy 14A, "Delegation and Monitoring."

DEFINITIONS:

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

PROCEDURES:

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

1. Providers must submit urgent preservice and urgent concurrent referrals within 24-hours of the determination that the referral is necessary.
2. For non-urgent preservice or concurrent referrals, Providers have two (2) working days from the determination that a referral is necessary, to submit the referral and all supporting documentation.
3. Providers must provide a direct phone number and fax number to the referring Physician for any questions or communication regarding the referral.

B. Determinations must be made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Providers. See Policy 14A, "Delegation and Monitoring."

C. Copies of referrals and any received consultations and/or service reports must be filed in the

Member's medical record.

1. Each Specialist provides written documentation of findings and care provided or recommended to the PCP within two (2) weeks of the Member encounter.
2. The PCP evaluates the Specialist reports, documents their review in the Member's medical record, and formulates a follow-up care plan for the Member if applicable. This follow-up plan must be documented in the Member's medical record.
3. The presence of Specialist reports on the PCP's medical records is reviewed during Facility Site Review and Medical Record Review Survey, Interim Audits, and/or Focused Audits, or as required in accordance with Policy 7A, "PCP and IPA Medical Record Requirements."

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

E. The PCP may use either the PCP Referral Tracking Log (see Attachment/"PCP Referral Tracking Log" found on the IEHP website[1]) or another system that contains the following required information:

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

F. The PCP Referral Tracking Log or equivalent must always be available at the PCP site. This

[1] https://www.iehp.org/en/providers/provider-resources?target=forms
[2] CA Health & Saf. Code § 1374.16(c)

is reviewed during Facility Site Review and Medical Record Review Survey, Interim Audits, and/or Focused Audits, or as required in accordance with Policy 7A, "PCP and IPA Medical Record Requirements."

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

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

I. Monitoring and Oversight

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

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

3. IEHP will also issue a Corrective Action Plan (CAP) within one (1) business day of the date the audit is performed (See Attachments, "Referral Audit Corrective Action Plan Tool" and "Referral Audit CAP Notification Letter" found on the IEHP website).[3]

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

14. UTILIZATION MANAGEMENT

A. Review Procedures
2. Standing Referral/Extended Access to Specialty Care

APPLIES TO:

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

POLICY:

A. IEHP and its IPAs are required to establish and implement procedures for Primary Care Providers (PCPs) to request a standing referral to a Specialist or specialty care center for a Member who, as a component of ongoing ambulatory care, requires continuing specialty care over a prolonged period of time, or extended access to a Specialist for a Member who has a life threatening, degenerative, or disabling condition that requires coordination of care by a Specialist.[1]

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

PROCEDURES:

A. Practitioners that are Board-eligible in appropriate specialties, e.g., Infectious Disease, can treat conditions or diseases that involve a complicated treatment regimen that requires ongoing monitoring. Board certification is verified during the Provider credentialing process. Members may obtain a list of Providers in IEHP's Provider network by:

   1. Contacting IEHP Member Services Department at (877) 273-4347 or TTY (800) 718-4347; or
   2. Accessing Doctor Search online at www.iehp.org.

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

C. Potential conditions necessitating a standing referral and/or treatment plan include but are not limited to the following:

   1. Significant cardiovascular disease;
   2. Asthma requiring specialty management;
   3. Diabetes requiring Endocrinologist management;
   4. Chronic obstructive pulmonary disease;
   5. Chronic wound care;

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

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

D. Potential conditions necessitating extended access to a Specialist or specialty care center and/or treatment plan include but are not limited to the following:

1. Hepatitis C;
2. Lupus;
3. HIV;
4. AIDS;
5. Cancer;
6. Potential transplant candidates;
7. Severe and progressive neurological conditions;
8. Renal failure; and
9. Cystic fibrosis.

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

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

[2] https://www.iehp.org/en/providers/provider-resources?target=forms
[3] CA Health & Saf. Code § 1374.16(c)

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

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

G. When authorizing a standing referral to a Specialist for the purpose of the diagnosis or treatment of a condition requiring care by a Physician with a specialized knowledge of HIV medicine, the Member must be referred to an HIV/AIDS Specialist.[5] When authorizing a standing referral to a Specialist for purposes of having that Specialist coordinate the care of a Member, who is infected with HIV, the Member must be referred to an HIV/AIDS Specialist.[6]

Out of Network

A. IEHP and its IPAs arrange for and cover any out-of-network services adequately and timely when such services are medically necessary and not available within the network and according to timely access standards.[7]

B. IEHP and its IPAs are not required to refer Members to an out-of-network HIV/AIDS specialist unless an appropriate HIV/AIDS specialist, or qualified nurse practitioner, or physician assistant under the supervision of an HIV/AIDS specialist is not available within the network, as determined by the IPA in conjunction with IEHP's Chief Medical Officer or designee.[8]

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[4] CA Health & Saf. Code § 1374.16(c)
[5] Title 28, California Code of Regulations § 1300.74.16(f)
[6] Ibid.
[7] CA Health & Saf. Code § 1342.72
[8] 28 CCR § 1300.74.16(g)

14. UTILIZATION MANAGEMENT

B. Second Opinions

APPLIES TO:

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

POLICY:

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

PROCEDURES:

Requesting Second Opinion

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

B. Members may request a second opinion through their PCP or Specialist. If the PCP or Specialist refuses to submit a request for a second opinion, the Member can submit a grievance or a request for assistance through IEHP Member Services at (877) 273-4347. IEHP's Member Services staff directs the Member to their IPA to request a second opinion.

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

Timeframes

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

B. In cases where the Member faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb or other major bodily function, or lack of timeliness that would be detrimental to the Member's ability to regain maximum function, decisions and notification of decisions to the Member and Provider are completed within 72 hours of receiving the request, whenever possible.[2]

Authorizing Second Opinion Requests

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

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

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

procedures;

2. The Member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment including but not limited to a serious chronic condition;
3. Clinical indications are not clear or are complex and confusing, a diagnosis is questionable due to conflicting test results, or the treating Provider is unable to diagnose the condition and the Member requests an additional diagnostic opinion;
4. The treatment plan in progress is not improving the medical condition of the Member within an appropriate time period given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment; and
5. The Member has attempted to follow the plan of care or consulted with the initial Provider concerning serious concerns about the diagnosis or plan of care.

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

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

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

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

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

G. Behavioral Health (BH) Providers who complete a second opinion evaluation or consultation must submit the "BH Initial Evaluation Coordination of Care Report" to the IEHP Behavioral health and Care Management Department through the secure IEHP Provider portal as expeditiously as the Member's condition requires, but no later than two (2) weeks of a non-urgent visit or 24 hours of an urgent visit. BH Providers can receive training

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

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

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

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

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

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

Monitoring and Oversight

A. The PCP is responsible for documenting second opinion requests and monitoring receipt of consultation reports on the PCP Referral Tracking Log (See "PCP Referral Tracking Log" located on the IEHP website[10]). See Policy 14A1, "Review Procedures – Primary Care Provider (PCP) Referrals."

B. IPAs must utilize a Second Opinion Tracking Log to track the status of second opinion requests and to ensure that the second opinion Provider provides the consultation report within three (3) working days of the visit (See "Second Opinion Tracking Log" located on the IEHP website[11]). See Policy 25E2, "Utilization Management - Reporting Requirements."

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

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[9] CA Health & Saf. Code § 1383.15(i)
[10] https://www.iehp.org/en/providers/provider-resources?target=forms
[11] Ibid.

14. UTILIZATION MANAGEMENT

C. Emergency Services

APPLIES TO:

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

POLICY:

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

B. Prior authorization is not required for the MSE (or COBRA exam) performed at an ED, to the extent necessary to determine the presence or absence of an emergency medical condition, or for services necessary to treat and stabilize an emergency medical condition.

DEFINITIONS:

A. Emergency medical condition - A medical condition, mental or physical which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:[2, 3,4]

   1. Placing the health of the individual (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
   2. Serious impairment to bodily function; or
   3. Serious dysfunction of any bodily organ or part.

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

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

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

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

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

PROCEDURES:

A. Healthcare professionals must have internal policies and procedures that delineate what steps are to be taken in the event a Member presents to their office with a medical or psychiatric emergency requiring immediate intervention. These steps should include when office staff or Practitioners should call 911. Providers need to ensure all office staff and Practitioners are trained on how to handle these types of emergencies.[8]

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

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

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

Post-Stabilization Care

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

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

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

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

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

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

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

All subsequent days are subject to review for medical necessity.

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

   a. An IEHP or IPA physician with privileges at the emergency physician's hospital assumes responsibility for the Member's care;

   b. An IEHP or IPA physician assumes responsibility for the Member's care through transfer;

   c. The IEHP or IPA physician and the attending emergency physician are able to reach an agreement concerning the Member's care; or

   d. The Member is discharged.

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

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

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

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

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

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

14. UTILIZATION MANAGEMENT

C. Emergency Services

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14. UTILIZATION MANAGEMENT

D. Pre-Service Referral Authorization Process

APPLIES TO:

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

POLICY:

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

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

DEFINITIONS:

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

PROCEDURES:

Provider Responsibilities

A. Referral forms from the PCP or Specialist must include the following information:

1. Designation of the referral request as either routine or expedited to define the priority of the response.
    a. Referrals that are not prioritized are handled as "routine."
    b. Referrals that are designated as "expedited" must include the supporting documentation regarding the reason the standard timeframe for issuing a determination could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function (See Policy 14I, "Expedited Initial Organization Determinations");
2. The diagnosis (ICD) and procedure (CPT) codes;
3. Pertinent clinical information supporting the request; and
4. Signature of referring Provider and date. This may consist of handwritten signature, handwritten initials, unique electronic identifier, or electronic signatures that can demonstrate appropriate controls to ensure that only the individual indicated may enter a

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

signature.

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

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

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

IEHP and Delegate Responsibilities

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

B. Prior authorization may be used for one or more of the following purposes:[2]

1. To confirm the presence of diagnoses or other medical criteria that are the basis for coverage determination for the specific item or service; or
2. To ensure an item or service is medically necessary; or
3. For supplemental benefits, to ensure that the furnishing of a service or benefit is clinically appropriate.

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

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

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

1. Verification of Member eligibility by the Delegate;
2. Written documentation by the referring Provider of medical necessity for a service, procedure, or referral;
3. Verification by the Delegate that the place of service and requested Provider is within the IEHP network;

[2] Title 42 Code of Federal Regulations (CFR) §422.138 (b)

4. Assessment of medical necessity and appropriateness of level of care with determination of approval or denial of the proposed service or referral; and
5. Consulting with the referring Provider, when appropriate.

E. IEHP and its Delegates consistently apply criteria and standards for approving, partially approving (modifying or authorizing an amount, duration or scope that is less than requested), or denying requested services. See Policy 14A, "Utilization Management – Delegation and Monitoring."

F. IEHP and its Delegates ensure that decisions to deny or partially approve (modify) are made by a qualified health care professional with appropriate clinical expertise in the condition and disease.[3] Please see Policy 14A, "Utilization Management – Delegation and Monitoring," for more information.

G. IEHP and its Delegates must have a process that facilitates the Member's access to needed specialty care by issuing a prior authorization of, at a minimum, a consult and up to two (2) follow up visits for medically necessary specialty care. Prior authorization for medically necessary procedures or other services that can be performed in the office, beyond the initial consultation and up to two (2) follow up visits, should be authorized as a set or unit. For example, when approving an ENT consultation for hearing loss, an audiogram should be approved (See Attachment, "Specialty Office Service Auth Sets Grid" found on the IEHP website[4]).

H. IEHP and its Delegates must have a process in place to allow a Specialist to directly request authorization from IEHP or the Delegate for additional specialty consultation, diagnostic, or therapeutic services.

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

1) Emergency Services (see Policy 14C, "Emergency Services");[5]
2) Family planning (see Policy 10K, "Family Planning Services");
3) Abortion services (see Policy 9D, "Access to Services with Special Arrangements");
4) Sexually transmitted infection (STI) diagnosis and treatment (see Policy 10G, "Sexually Transmitted Infection (STI) Services");
5) Sensitive and confidential services (see Policy 9D, "Access to Services with Special Arrangements");
6) HIV testing and counseling at the Local Health Department (see Policy 10H, HIV Testing and Counseling");

[3] Medicare Managed Care Manual "Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance," Section 40.9.
[4] https://www.iehp.org/en/providers?target=forms
[5] Medicare Managed Care Manual "Chapter 4 – Benefits and Beneficiary Protections," Section 20.3

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

8) Out of area renal dialysis;[6]

9) Biomarker testing for advanced or metastatic stage 3 or 4 cancers;[7]

   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.[8]

10) Urgent care;

11) Initial mental health and substance use disorder (SUD) assessments;

12) Preventative services;[9] and

13) Other services as specified by the CMS.

J. Referrals to out-of-network practitioners require documentation of medical necessity, rationale for the requested out-of-network referral, and prior authorization from the Delegate (see Attachment, "Health Plan Referral Form for Out-of-Network and Special Services" found on the IEHP website[10]). Once the prior authorization has been obtained, the PCP's office should assist the Member with making the appointment, continuing to monitor the Member's progress to ensure appropriate intervention, and ensure a safe transition back into the network.

K. Determinations must be made in a timely manner, not to exceed regulatory turnaround timeframes for determination and written notification of Members and Practitioners (see Attachment, "UM Timeliness Standards – IEHP DualChoice" found on the IEHP website[11]). [12] See Policy 14A, "Utilization Management - Delegation and Monitoring."

L. A Member or Provider who is not able to obtain a timely referral to an appropriate Provider can file a complaint with the Department of Managed Health Care (DMHC):[13]

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

M. In the event a Specialist is terminated voluntarily, or as directed by IEHP, the IPA coordinates

[6] Medicare Managed Care Manual "Chapter 4 – Benefits and Beneficiary Protections," Section 110.1.3.
[7] California Health and Safety Code (CA HSC) §1367.665
[8] https://www.accessdata.fda.gov/scripts/cder/daf/
[9] Title 45 Code of Federal Regulations (CFR) 147.130 "Coverage of Preventive Health Services"
[10] https://www.iehp.org/en/providers?target=forms
[11] Ibid.
[12] Title 42 CFR §§ 438.210, 422.568, 422.570, and 422.572
[13] CA Health & Saf. Code § 1367.01(e)

the redirection of the Members' care as needed.

N. If a covered item or service receives approval through the prior authorization process, IEHP and it's Delegates may not deny coverage later on the basis of medical necessity and may not reopen such a decision for any reason except if there is reliable evidence of fraud or similar fault, or if good cause for reopening has been established.[14]

1. Good cause may be established when there is new and material evidence that: [15]
   a. Was not available or known at the time of the determination or decision; and
   b. May result in a different conclusion.
2. Alternately, good cause may be established when the evidence that was considered in making the determination or decision clearly shows on that an obvious error was made at the time of the determination or decision.

Monitoring and Oversight

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

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

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

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

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

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[14] Title 42 Code of Federal Regulations (CFR) §422.138 (c)
[15] Title 42 Code of Federal Regulations (CFR) §405.986 (a)

14. UTILIZATION MANAGEMENT

E. Referral Procedure for Custom Wheelchairs and Powered Mobility Devices

APPLIES TO:

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

POLICY:

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

DEFINITIONS:

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

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

PROCEDURES:

IPA Responsibilities

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

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

C. The IPA must review requests for custom wheelchair/powered mobility devices that meet Medicare criteria following their prior authorization procedures. Determinations must be made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Providers (See "UM Timeliness Standards – IEHP DualChoice" found on the IEHP website[2]). See Policy 25E1, "Utilization Management Delegation and Monitoring" for prior authorization process requirements.

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

[1] Medicare Managed Care Manual, "Benefits and Beneficiary Protections," Section 10.12
[2] https://www.iehp.org/en/providers/provider-resources?target=forms

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

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

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

IEHP Responsibilities

A. IEHP reviews referral and supporting documentation submitted by the IPA. Final determinations are made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Providers (See "UM Timeliness Standards – IEHP DualChoice" found on the IEHP website[3]).

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

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

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

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

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

E. Referral Procedure for Custom Wheelchairs and Powered Mobility Devices

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14. UTILIZATION MANAGEMENT

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

APPLIES TO:

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

POLICY:

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

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

PURPOSE:

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

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

DEFINITIONS:

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

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

PROCEDURES:

Custodial Level Long-Term Care and Provider Responsibilities

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

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

B. For Members directly admitted from the community, the treating Primary Care Provider (PCP) or Specialist must submit a referral to the Member's assigned IPA requesting admission. Determinations must be made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Practitioners (see "UM Timeliness Standards – Medi-Cal" found on the IEHP website[3]).[4] See Policy 14D, "Pre-Service Referral Authorization Process."

C. Within 48 hours[5] of the Member's admission, the LTC facility must submit to the IPA all clinical documentation that demonstrate the medical necessity of the inpatient admission. If clinical documents are not received timely, the inpatient admission will be at risk for potential denial.

D. Prior to transferring a Member to a hospital, or before a Member goes on therapeutic leave, the LTC facility must provide written information to the Member or Member's representative that specifies:[6]

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

E. If an LTC facility determines that a Member who was transferred with an expectation of returning to the facility cannot return to the facility, the facility must follow the procedure for discharge in accordance with applicable state and federal requirements.[8]

F. The LTC facility must submit all clinical documentation in advance of, or at the time of the Member's discharge or transfer, and no later than within two (2) business days post-discharge.[9] If clinical documentation is not received timely, IEHP will issue a denial of payment to the facility due to lack of clinical documentation supporting medical necessity.

[3] https://www.iehp.org/en/providers/provider-resources?target=forms
[4] Title 42 Code of Federal Regulations (CFR) §§ 438.210, 422.568, 422.570, and 422.572
[5] Department of Managed Health Care (DHCS) CalAIM Dual Eligible Special Needs Plans (D-SNP) Policy Guide – Chapter 2, Information Sharing Policy
[6] 42 CFR §483.15 (d)
[7] 42 CFR §483.15 (e)(1)
[8] 42 CFR §483.15 (e)(1)(ii)
[9] Ibid.

G. Contracted LTC facilities must use secure methods, including fax, telephone, and/or electronic data record exchange, to inform IEHP of any LTC admission, discharge, or transfer, for all Members.[10]

IEHP, IPA & PCP Responsibilities

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

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

C. IEHP will authorize Accommodation Codes as follows:

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

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

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

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[10] Ibid.

14. UTILIZATION MANAGEMENT

F. Long Term Care
2. Skilled Level

APPLIES TO:

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

POLICY:

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

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

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

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

PURPOSE:

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

DEFINITIONS:

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

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

PROCEDURES:

Skilled Level Long-Term Care and Provider Responsibilities

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

14. UTILIZATION MANAGEMENT

F. Long Term Care
2. Skilled Level

A. Primary Care Providers (PCPs) must evaluate a Member's need for skilled level LTC. A referral request must be submitted to the Member's IPA with sufficient medical information from the Member's PCP when transitioning from a/the community or usual setting. Determinations must be made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Practitioners (see "UM Timeliness Standards – IEHP DualChoice" found on the IEHP website[3]).[4] See Policy 14D, "Pre-Service Referral Authorization Process."

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

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

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

C. Appropriately licensed staff must assist in the evaluation and placement of Members into LTC facilities including involvement in the development, management, and monitoring of Member

[3] https://www.iehp.org/en/providers?target=forms
[4] Title 42 Code of Federal Regulations (CFR) §§ 438.210, 422.568, 422.570, and 422.572

treatment plans.

D. Within 48 hours[5] of the Member's admission, the LTC facility must submit to the IPA all clinical documentation that demonstrate the medical necessity of the inpatient admission. If clinical documents are not received timely, the inpatient admission will be at risk for potential denial.

E. The treatment plan is implemented, evaluated, and revised by the LTC facility's team of Providers and staff including, but not limited to, UM and/or CM staff, physicians, long term care Providers and staff, and IEHP or the IPA, as appropriate. The Member and family are also involved in the implementation of the treatment plan to the extent necessary.

F. Unless directed otherwise by IEHP, the LTC facility must, on a weekly basis, inform IEHP of the expected outcome of the Member's health status. This includes but is not limited to clinical updates, status of goals, and discharge planning (See "Long Term Care (LTC) Initial Review Form" and "Long Term Care (LTC) Follow-Up Review Form" found on the IEHP website[6]).

G. Prior to transferring a Member to a hospital, or before a Member goes on therapeutic leave, the LTC facility must provide written information to the Member or Member's representative that specifies:[7]

1. That the Member has a right to a seven (7) day bed hold, during which the Member is permitted to return and resume residence.
2. The LTC facility's policy regarding bed holds, consistent with the following:
    a. If the Member's hospitalization or therapeutic leave exceeds the bed hold period of seven (7) days, but the Member still requires the services provided by the LTC facility and is still eligible for said services, the Member may still return to their previous room if available, otherwise they will be able to return immediately upon the first availability of a bed in a semi-private room.[8]

H. If an LTC facility determines that a Member who was transferred with an expectation of returning to the facility cannot return to the facility, the facility must follow the procedure for discharge in accordance with applicable state and federal requirements.[9]

I. The LTC facility must submit all clinical documentation in advance of, or at the time of the Member's discharge or transfer, and no later than within one (1) business day post-discharge.[10] If clinical documentation is not received timely, IEHP will issue a denial of payment to the

[5] Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plans (D-SNP) Policy Guide – Chapter 2, Information Sharing Policy
[6] https://www.iehp.org/en/providers/provider-resources?target=forms
[7] 42 CFR §483.15 (d)
[8] 42 CFR §483.15 (e)(1)
[9] 42 CFR §483.15 (e)(1)(ii)
[10] Ibid.

facility due to lack of clinical documentation supporting medical necessity.

J. Contracted LTC facilities must use secure methods, including fax, telephone, and/or electronic data record exchange, to inform IEHP of any LTC admission, discharge, or transfer, for all Members.[11]

K. The facility provides the Member or their representative a written or electronic notification of the decision of non-coverage of further LTC skilled no later than two (2) calendar days prior to proposed termination of services.[12,13],[14]

1. The Notice of Medicare Non-Coverage (NOMNC) letter may be delivered earlier if the date that coverage will end is known.[15]
2. If the expected length of stay or service is two (2) days or less, the NOMNC letter must be given on admission.[16]
3. The NOMNC should not be used when it is determined that the Member's services should end based on the exhaustion of benefits (such as the one hundred (100) day long term care limit per benefit period).
4. The facility may deliver the NOMNC to the Member's representative. If the facility is unable to personally deliver the NOMNC to the Member's representative, then the facility should inform the representative of the following:[17]
    a. The Member's last day of covered services, and the date when the Member's liability is expected to begin;
    b. The Member's right to appeal;
    c. A description of how to request appeal by a Quality Improvement Organization (QIO);
    d. The deadline to request a review as well as what to do if the deadline is missed; and
    e. The name and telephone number of the Quality Improvement Organization (QIO).

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

    When direct phone contact cannot be made, the facility shall send the NOMNC to the Member's representative by certified mail, return receipt requested. The date that

[11] Ibid.
[12] Title 42 Code of Federal Regulations (CFR) § 422.624 (b)(1)
[13] Medicare Claims Processing Manual, "Chapter 30 – Financial Liability Protections," Section 260.3.4
[14] Medicare Managed Care Manual "Chapter 4 – Benefits and Beneficiary Protections", Section 10.13
[15] 42 CFR § 422.624 (b)(1)
[16] Ibid.
[17] Medicare Claims Processing Manual, "Chapter 30 – Financial Liability Protections," Section 260.3.8

someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt for the NOMNC letter. [18]

5. IEHP DualChoice Members have the right to request an immediate review by the Beneficiary and Family-Centered Care QIO (BFCC-QIO) when a facility decides to terminate previously approved coverage.[19,20]

6. The facility must issue the Detailed Explanation of Non-Coverage (DENC) to QIO no later than the date specified and the facility must issue a copy to the Member.[21]

IEHP, IPA & PCP Responsibilities

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

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

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

D. IEHP and its IPAs provide all necessary care coordination for Members in LTC facilities, including coordination of all aspects of the admission, such as but not limited to:

1. Determining the appropriate contracted facility for the Member;
2. Arranging any necessary transportation services;
3. Arranging for physician coverage at the facility as needed;
4. Arranging for any necessary transfer of medical information; and
5. If the IPA determines the need to keep the Member in their usual setting with additional ancillary services, then the IPA may contact IEHP's Care Management Department.

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

F. The criteria for admission of Medi-Cal Members to various levels of LTC facilities are described in the following sections of Title 22 of the California Code of Regulations:[22]

[18] Medicare Claims Processing Manual, "Chapter 30 – Financial Liability Protections," Section 260.3.8
[19] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 100.2
[20] Medicare Claims Processing Manual, "Chapter 30 – Financial Liability Protections," Section 260.2
[21] Medicare Claims Processing Manual, "Chapter 30 – Financial Liability Protections," Section 260.4.4
[22] Title 22 California Code of Regulations (CCR) § 51124

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

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

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

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

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

1. Clinical progress notes must be received within two (2) business days of admission and at least weekly until discharge, unless directed otherwise by the IEHP LTC Review Nurse.
2. Timely submission of clinical progress notes is required in order to determine whether continued stay at this level of care remains medically necessary. Therefore, untimely submission of clinical progress notes could result in denial of skilled days.
3. Discharge planning should begin upon admission. IEHP must be informed of any discharge need requiring authorization as soon as need is known and prior to day of discharge (see "Service Request Form for Skilled Nursing Facilities" found on the IEHP website[23]).

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

K. UM staff, together with the interdisciplinary team of Providers and staff, guide the Member

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

toward meeting the treatment plan goals that include transfer to a lower level of care when it is medically appropriate.

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

M. Transfer to a board and care or home environment is initiated when it is determined that the Member is at a "custodial" level of care and can be safely managed at a lower level of care (based upon the Member's benefit).

N. Financial responsibility for IEHP DualChoice Members continues for up to 100 days per benefit period. The IPA will ensure that the Member is admitted to a contracted facility, as applicable. The IPA is responsible for notifying the Member**,** assigned PCP, and LTC facility that the benefits expire after 100 days of inpatient care per benefit period, and again prior to the Member exceeding the 100 days benefit limit.

O. On the 15th of each month, IPAs must notify IEHP of Members who are receiving skilled care as of the previous month or are estimated to require skilled care greater than the one hundred (100) days LTC skilled limit per benefit period by faxing the LongTerm Care (LTC) Data Sheet along with the face sheet to (909) 912-1045. (See "Long Term Care (LTC) Data Sheet" found on the IEHP website).

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

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

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

R. IEHP will authorize bed holds as follows.

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

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

T. IEHP will authorize Accommodation Codes as follows:

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

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14. UTILIZATION MANAGEMENT

G. Acute Inpatient and Behavioral Health Admission and Concurrent Review

APPLIES TO:

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

POLICY:

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

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

PURPOSE:

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

PROCEDURES:

BH Admission and Concurrent Review

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

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

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

Hospital/Facility Responsibilities

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

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

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

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

1. For IEHP-Direct Members, notification of acute admission may be done via fax at (909) 477-8553, phone or electronic data record exchange. Non-contracted facilities can notify IEHP of admission 24 hours a day by phone at (866) 649-6327.
2. For BH admissions, notification may be faxed to IEHP at (844) 500-0440. Non-contracted BH facilities can notify IEHP of admission 24 hours a day by phone at (866) 649-6327.
3. Hospitals do not need to supply IEHP a notification of admission for standard obstetric (OB) deliveries. No prior authorization is needed for these services and hospitals should bill post-discharge. Please refer to Section 20 "Claims Processing" for additional guidance on billing procedures. Length of stay for standard OB deliveries is defined as follows:[5]
    a. Two (2)-day stay for vaginal delivery
    b. Four (4)-day stay for cesarean delivery

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

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

D. The Hospital or LTAC facility must begin discharge planning upon admission and inform the Member's IPA for acute admission or IEHP for BH admission, of any discharge needs requiring authorization as soon as need is known and no later than the day prior to day of discharge (see "Acute Hospital Discharge Needs Request Form" found on the IEHP website[6]).

[4] Department of Managed Health Care (DHCS) CalAIM Dual Eligible Special Needs Plans (D-SNP) Policy Guide – Chapter 2, Information Sharing Policy
[5] Title 45 Code of Federal Regulations (CFR) §146.130
[6] https://www.iehp.org/en/providers/provider-resources?target=forms

E. Discharge planning must ensure that necessary care, services, and supports are in place in the community for the Member once they are discharged from the Acute or BH Hospital/Facility or LTAC, including scheduling an outpatient appointment and/or conducting follow-up with the Member and/or caregiver.[7] Discharge planning must include, at minimum:

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

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

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

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

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

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

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

are inpatient about their Hospital discharge appeal rights.[8]

1. Facilities must issue the Important Message from Medicare (IM) within two (2) calendar days of admission, must obtain the signature of the Member or his or her representative and provide a copy at that time to the Member/Member's representative.[9] A follow-up copy of the signed IM must be delivered to the Member:[10]
    a. A follow up copy must be delivered no more than two (2) calendar days before the planned date of discharge.
    b. When discharge cannot be predicted in advance, the follow up copy may be delivered as late as the day of discharge giving the Member at least four (4) hours to consider their right to request a QIO review.
    c. If delivery of the original IM is within two (2) calendar days of the date of discharge, no follow up notice is required.
2. If the Member is not able to comprehend the contents of the notice, the notice must be delivered to and signed by an authorized representative for the Member.[11]
3. If the Member refuses to sign the notice, the notice is still valid as long as the Provider documents that the notice was given, but the Member refused to sign.[12]
4. When a QIO notifies the Hospital that the Member has requested an expedited review, the facility delivers to the Member the Detailed Notice of Discharge. This template is available online at www.iehp.org.

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

IPA & PCP Responsibilities for Non-BH Inpatient Utilization Management

A. IPAs are responsible to perform inpatient utilization management activities as outlined in their contract. IPAs that have accountability for inpatient utilization management must notify IEHP of Members with inpatient stay on day 20 and weekly by completing and faxing the Acute Inpatient Data Sheet along with the face sheet to (909) 477-8553 (See "Acute Inpatient Data Sheet" found on the IEHP website[13]). Subsequent reviews must be sent to IEHP weekly until the Member is discharged.

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

[8] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 100.1
[9] Medicare Claims Processing Manual, "Chapter 30 – Financial Liability Protections, Section 200.3.1
[10] Medicare Claims Processing Manual, "Chapter 30 – Financial Liability Protections, Section 200.3.2
[11] Medicare Claims Processing Manual, "Chapter 30 – Financial Liability Protections, Section 200.3.1
[12] Ibid.
[13] https://www.iehp.org/en/providers/provider-resources?target=forms

admission.

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

D. Reviews are performed based on nationally recognized clinical criteria and IEHP Utilization Management Subcommittee Approved Authorization Guidelines. Reviews may also include physician communication and ongoing communication with other healthcare professionals involved in the Member's care, as necessary. Determinations are made within one (1) business day of receiving all clinical documentation, and are communicated to the facility within 24 hours of the decision.[14] Please see Policy 25E1, "Utilization Management Delegation and Monitoring" for more information on authorization process requirements.

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

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

E. If the Member's IPA denies the continued stay and the attending physician does not agree with the decision, either the attending physician or the Member may initiate an expedited appeal. Following completion of the expedited review process, the admission is either authorized or denied. Care must not be discontinued until the treating Practitioner has been notified and the treating Practitioner has agreed upon a care plan.[15] Please see Section 16, "Grievance and Appeal Resolution System" for more information.

F. For denials of care or service, the Member's IPA must notify the Hospital/Facility within twenty-four (24) hours of the receipt of request - i.e., receipt of clinical documentation. If oral notification is given within 24 hours of the request, then a written or electronic notification is given no later than three (3) calendar days after the oral notification. If the denial is either concurrent or post-service (retrospective) and the Member is not at financial risk, the Member does not need to be notified.[16]

G. IPAs must have post-transition discharge policies and procedures that ensure, in collaboration with IEHP, access to medical care and follow-up, medications, durable medical equipment (DME) and supplies, transportation, and integration of community-based Long-Term Services and Supports (LTSS) programs. Please see Policies 12A2, "Care Management Requirements

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

– Individual Care Plan" and 25C1, "Care Management – Delegation and Monitoring" for more information on care coordination and care management responsibilities that are delegated to IPAs.

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

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

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

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

Monitoring and Oversight

A. IEHP and its IPAs must ensure that Provider-Preventable Conditions (PPCs) are reported to the California Department of Health Care Services (DHCS).[17,18,] Please see Policy 13D, "Reporting Requirements Related to Provider Preventable Conditions" for more information.

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

14. UTILIZATION MANAGEMENT

H. Hospice Services

APPLIES TO:

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

POLICY:

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

PROCEDURE:

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

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

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

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

14. UTILIZATION MANAGEMENT

I. Expedited Initial Organization Determinations

APPLIES TO:

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

POLICY:

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

PROCEDURES:

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

B. An EIOD is automatically provided when the request is made or supported by a Provider. The Provider must indicate, either orally or in writing, that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.[3]

C. If it is determined that the Member's condition does not warrant an expedited determination, the IPA must verbally notify the Member within 72 hours of receipt of the request (includes weekends and holidays) followed by written notification within three (3) calendar days of the verbal notification.[4]

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

   a. Explains that the request will be processed using the five (5) calendar day timeframe for standard determinations;

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

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

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

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

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

This and other notification templates are available on the IEHP website[6].

2. The request will automatically be processed for a determination within the standard timeframe of five (5) calendar days from the day the request was received for an EIOD.[7]

D. If the request is accepted for an EIOD, the determination must be as expeditiously as the Member's health condition requires, and in accordance with the following requirements:[8]

1. Whether the decision is to approve, modify, or deny, written notification of the decision must be sent to the Member no later than 72 hours from when the request was received;

2. Written notification of the decision must also be sent to the Provider within 24 hours of the decision, and not to exceed 72 hours from when the request was received.

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

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

DI. Written communication regarding a modification or denial must be written in a manner that is understandable and sufficient in detail so that the Member and Practitioner can understand the rationale for the decision. See Policy 25E1, "Utilization Management – Delegation Monitoring" for denial notice requirements.

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

DIII. IEHP and IPAs will not extend the deadlines for initial organization determinations.[9]

[6] https://www.iehp.org/en/providers/provider-resources?target=forms
[7] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.12.1
[8] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 40.8
[9] Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide, Section VIII, Integrated Appeals and Grievances Requirements for EAE D-SNPs

14. UTILIZATION MANAGEMENT

I. Expedited Initial Organization Determinations

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

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