14. UTILIZATION MANAGEMENT

A. Delegation and Monitoring

APPLIES TO:

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

POLICY:

A. IEHP and its Delegates shall develop, implement, and continuously update and improve a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of medically necessary covered services.[1]

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

C. Authorization and financial responsibilities are delineated in the Division of Financial Responsibilities (DOFR). Delegated responsibilities are outlined in the IPA's Delegation Agreement.

PURPOSE:

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

DEFINITION:

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

PROCEDURES:

UM Program Requirements

A. Delegates must have a UM Program Description that includes, at minimum, the following information:[2]

   1. Mission statement, goals, and objectives;
   2. Program structure, which includes at minimum:
      a. UM staff's assigned activities;
      b. UM staff who have the authority to deny coverage;

[1] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program
[2] NCQA, 2023 HP Standards and Guidelines, UM 1, Element A

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;

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:[3]

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: [4]

   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,

[3] NCQA, 2023 HP Standards and Guidelines, UM 1, Element B
[4] NCQA, 2023 HP Standards and Guidelines, UM 1, Element A, Factor 1

requests by Providers prior to, retrospectively, or concurrent with the provision of health care services to Members comply with State, federal and contractual requirements;[5,6]

b. Ensuring that medical decisions are rendered by qualified medical personnel and are not influenced by fiscal or administrative management considerations; [7,8]

c. Participation in staff training;[9]

d. Monitoring documentation for adequacy;[10]

e. Be available to UM staff on site or by telephone;[11]

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.[12] For more information on a UM Committee's functions, structure, membership, and other requirements, please see Policy 2G, "Utilization Management Subcommittee."

3. **Use of Appropriate Professionals for UM Decisions:** To ensure that first-line UM decisions are made by individuals who have the knowledge and skills to evaluate working diagnoses and proposed treatment plans, IEHP requires its Delegates to adopt the following standards for personnel making review decisions and reviewing denials. The following types of personnel can perform the functions listed, as delegated to do so: [13]

   a. UM Technicians/Coordinators – eligibility determination, editing of referral form for completeness, interface with Provider offices to obtain any needed non-medical information,[14] 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.

[5] California Health and Safety Code (Health & Saf. Code) §1367.01
[6] NCQA, 2023 HP Standards and Guidelines, UM 4, Element A, Factor 1
[7] Title 22, California Code of Regulations (CCR) § 53857
[8] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 1.1.6, Medical Director
[9] NCQA, 2023 HP Standards and Guidelines, UM 4, Element A, Factor 1
[10] Ibid.
[11] Ibid.
[12] NCQA, 2023 HP Standards and Guidelines, UM 1, Element A, Factor 3
[13] NCQA, 2023 HP Standards and Guidelines, UM 4, Element A, Factor 2
[14] NCQA, 2023 HP Standards and Guidelines, UM 6, Element A

b. Licensed Vocational Nurses (LVN) – initial review of medical information, initial determination of benefit coverage, concurrent inpatient, obtaining additional medical information, as needed, from the Provider's offices,[15] and approval of referrals based on IEHP-approved authorization criteria, 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,[16] 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.[17,18,19,20,21]

4. **Use of Board-Certified Physicians for UM Decisions:** Delegates must have written policy and procedure demonstrating their use of designated physicians with current unrestricted license for UM decisions.[22]
   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.[23] Criteria sets approved by IEHP include Title 22 of the California Code of Regulations, InterQual, Apollo Managed Care Guidelines/Medical Review Criteria, Milliman

[15] NCQA, 2023 HP Standards and Guidelines, UM 6, Element A
[16] Ibid.
[17] CA Health & Saf. Code § 1367.01(e)
[18] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[19] NCQA, 2023 HP Standards and Guidelines, UM 4, Element A, Factor 1
[20] NCQA, 2023 HP Standards and Guidelines, UM 4, Element C
[21] NCQA, 2023 HP Standards and Guidelines, UM 6, Element A
[22] NCQA, 2023 HP Standards and Guidelines, UM 4, Element F, Factors 1 and 2
[23] NCQA, 2023 HP Standards and Guidelines, UM 2, Element A

Care Guidelines, Department of Health Care Services (DHCS) Medi-Cal Provider Manual, DHCS All Plan Letters (APLs), World Professional Association for Transgender Health standards of care, and IEHP UM Subcommittee-Approved Authorization Guidelines.[24,25] IEHP may distribute additional criteria following approval by the IEHP UM Subcommittee.

1. **Development:** Criteria or guidelines that are developed by IEHP and used to determine whether to authorize, partially approve (modify), or deny health care services are developed with involvement from actively practicing health care Practitioners.[26,27] IEHP ensures these criteria or guidelines are consistent with sound clinical principles and processes and are evaluated at least annually and updated if necessary.[28,29,30]
2. **Application:** Delegates must apply criteria in a consistent and appropriate manner based on available medical information and the needs of individual Members.[31] 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.[32] 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:[33]
    a. Availability of services, including but not limited to skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the Member after hospital discharge;
    b. Coverage of benefits for skilled nursing facilities, subacute care facilities, home care where needed, 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

[24] CA Health & Saf. Code § 1363.5(b)
[25] NCQA, 2023 HP Standards and Guidelines, UM 2, Element A, Factor 1
[26] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[27] NCQA, 2023 HP Standards and Guidelines, UM 2, Element A, Factor 4
[28] CA Health & Saf. Code §1363.5
[29] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[30] NCQA, 2023 HP Standards and Guidelines, UM 2, Element A, Factor 5
[31] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program
[32] NCQA, 2023 HP Standards and Guidelines, UM 2, Element A, Factor 2
[33] NCQA, 2023 HP Standards and Guidelines, UM 2, Element A, Factor 3

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:[34,35,36]

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

b. DHCS Medi-Cal Provider Manual **or** Title 22 of California Code of Regulations (CCR); **then**

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

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

e. InterQual Criteria; **then**

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

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

h. 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.[37,38]

4. **Process for Obtaining Criteria**: Delegates must disclose to Providers, Members, Member's representatives, or the public, upon request, the clinical guidelines or criteria used for determining health care services specific to the procedure or condition requested.[39,40]

[34] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program
[35] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[36] NCQA, 2023 HP Standards and Guidelines, UM 2, Element A, Factor 1
[37] DHCS-IEHP Primary Operations Plan Contract, Exhibit A, Attachment III, Provision 2.3.1, Utilization Management Program
[38] NCQA, 2023 HP Standards and Guidelines, UM 2, Element A, Factor 5
[39] CA Health & Saf. Code §1363.5
[40] NCQA, 2023 HP Standards and Guidelines, UM 2, Element B, Factors 1 and 2

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.

The Notice of Action (NOA) must state the address and phone number to call for obtaining the utilization criteria or benefits provision used in the decision.[41,42] 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[43]).[44] Delegates must maintain a log of all requests for criteria (See "Request for UM Criteria Log" found on the IEHP website[45]).

5. **Annual Assessment of Consistency of UM Decisions (Inter-rater Reliability):** Delegates are responsible for evaluating, at least annually, the consistency with which health care professionals involved in utilization review apply appropriate criteria for decision-making.[46] Delegates must act on identified opportunities to improve consistency.[47] The sample assessed must be statistically valid, or Delegates may use one (1) of the following three (3) auditing methods: [48]

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

   b. NCQA's 8/30 methodology; or

   c. Ten (10) hypothetical cases.

UM Authorization Process Requirements

A. Delegates must have written policies and procedures regarding the process to review, approve, partially approve (modify) or deny prospective, concurrent or retrospective requests by Providers concerning provision of health care services for Members. These policies and procedures must be available to the public upon request.[49]

[41] DHCS All Plan Letter (APL) 21-011 Supersedes APL 17-006, "Grievance and Appeals Requirements, Notice and "Your Rights" Templates
[42] NCQA, 2023 HP Standards and Guidelines, UM 7, Element B, Factor 3
[43] https://www.iehp.org/en/providers/provider-resources?target=forms
[44] CA Health & Saf. Code §1363.5
[45] https://www.iehp.org/en/providers/provider-resources?target=forms
[46] NCQA, 2023 HP Standards and Guidelines, UM 2, Element C, Factor 1
[47] NCQA, 2023 HP Standards and Guidelines, UM 2, Element C, Factor 2
[48] NCQA, 2023 HP Standards and Guidelines, UM 2, Element C, Factor 1
[49] CA Health & Saf. Code § 1367.01(b)

14. UTILIZATION MANAGEMENT

A. Delegation and Monitoring

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.[50]
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.[51]
3. **Out-of-Network Services:** Authorization and notification of decision for proposed services, referrals, or hospitalizations involves utilizing information such as medical records, test reports, specialist consults, and verbal communication with the requesting Provider. Part of this review process is to determine if the service requested is available in network. If the service is not available in network, arrangements are made for the Member to obtain the service from an out of-network provider for this episode of care.[52]

   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 through IEHP's secure Provider portal to prevent any delay in care. IEHP will communicate to the Delegate if the request can be handled within the network or does not meet the criteria. In which case, the Delegate can modify or deny as appropriate.
4. **Prior Authorization Requirements:** Delegates must maintain a list of services that require prior authorization or a list of services that do not require prior authorization like below, at minimum.
   a. The prior authorization process described in this policy do not apply to these services, which do not require prior authorization:
      1) Emergency services and services necessary to treat and stabilize an emergency medical condition (See Policy 14C, "Emergency Services");[53,54,55]

[50] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program
[51] NCQA, 2023 HP Standards and Guidelines, UM 12, Element A
[52] NCQA, 2023 HP Standards and Guidelines, MED 1, Element D
[53] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[54] DHCS-IEHP Two Plan Contract, Exhibit A, Attachment III, Provision 2.3.2, Timeframes for Medical Authorization
[55] NCQA, 2023 HP Standards and Guidelines, MED 9, Element C, Factors 1 through 3

2) Family planning (See Policy 10G, "Family Planning Services");[56,57]
3) Abortion services (See Policy 9E, "Access to Services with Special Arrangements"); [58]
4) Sexually Transmitted Infection (STI) services (See Policy 10H, "Sexually Transmitted Infection (STI) Services"); [59,60]
5) Sensitive and confidential services (See Policy 9E, "Access to Services with Special Arrangements");
6) HIV testing and counseling (See Policy 10I, HIV Testing and Counseling"); [61,62]
7) Immunizations (See Policy 10C2, "Pediatric Preventive Services – Immunization Services"); [63]
8) Routine OB/GYN services, including prenatal care by Family Care Practitioner (credentialed for obstetrics) within the IPA's network;[64,65]
9) Out of area renal dialysis; [66]
10) Biomarker testing for advanced or metastatic stage 3 or 4 cancers;[67,68]
    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.[69]
11) Urgent Care; and

[56] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[57] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[58] DHCS APL 22-022 Supersedes APL 15-020, "Abortion Services"
[59] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[60] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[61] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[62] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[63] DHCS All Plan Letter (APL) 18-004 Supersedes Policy Letter (PL) 96-013 and APL 07-015, "Immunization Requirements"
[64] Ibid.
[65] NCQA, 2023 HP Standards and Guidelines, MED 1, Element A
[66] DHCS Medi-Cal Provider Manual, "Dialysis: End Stage Renal Disease Services"
[67] California Health and Safety Code (CA HSC) §1367.665
[68] DHCS APL 22-010 "Cancer Biomarker Testing"
[69] https://www.accessdata.fda.gov/scripts/cder/daf/

12) Preventive services,[70] which includes the following services and those listed in the DHCS Medi-Cal Provider Manual Preventive Services List:[71]

a) Bone Density Screening (CPT Codes: 77080 and 77081);

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

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

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

c. Delegates must allow Members direct access to Specialists, appropriate for their condition and identified need for special healthcare needs.[72]

d. Delegates shall ensure Members have access to American Indian Health Services Programs (AIHSP). AIHSP, whether contracted or not, can provide referrals directly to network Providers without first requesting a referral from a PCP.[73]

5. **Medical Necessity Determination:** Delegates must determine medical necessity for a specific requested service as follows: [74]

a. Employ IEHP-approved UM authorization guidelines, as outlined in this policy, and utilize the following definitions for determining medical necessity of a healthcare service: [75]

1) For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity," when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

2) For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity," when the service is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services.

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

[70] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[71] Preventive Services (prev) (ca.gov)
[72] NCQA, 2023 HP Standards and Guidelines, MED 1, Element B, Factor 1
[73] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[74] NCQA, 2023 HP Standards and Guidelines, UM 1, Element A, Factor 5
[75] CA Welfare and Institutions Code (Welf. & Inst. Code) § 14059.5

by a Medical Director. The request for additional information must be annotated and include the date of request.[76]

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.[77,78]

6. **Review Process and Timeframes:** Mandated timeframes for decisions including approval, denial or partial approval (modification) of a request and subsequent notification to the Member and Provider are outlined in this Provider Manual (see "UM Timeliness Standards – Medi-Cal" found on the IEHP website[79]).

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

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

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

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

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

Using the "Notice of Delay" template, the Delegate must notify the Member and requesting Provider within the required timeframe, or as soon as the Delegate becomes aware that it will not meet the initial authorization timeframe, whichever is earlier.[80] This notification must include the specific information requested but not received, expert reviewer to be consulted, or the additional examinations or

[76] NCQA, 2023 HP Standards and Guidelines UM 6, Element A
[77] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[78] NCQA, 2023 HP Standards and Guidelines, UM 4, Element F, Factors 1 and 2
[79] https://www.iehp.org/en/providers/provider-resources?target=forms
[80] CA Health & Saf. Code § 1367.01(h)(5)

tests required before the service can be approved or denied.[81] See the section on "Notification Requirements" within this policy.

c. Delegates will identify upon intake any prior authorization request for which IEHP is responsible to authorize and will ensure these requests are forwarded to IEHP within one (1) business day of receipt by forwarding the request through the IEHP secure Provider portal. Examples of services/items to be forwarded are requests for behavioral health, general anesthesia for dental treatment, inpatient surgery requests when the facility is not contracted with IEHP, POV purchase/repair.

d. 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.[82]

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

   1) Member's condition is such that the Member faces an imminent and serious threat to their health, including but not limited to potential loss of limb or other major bodily function, or when the non-urgent timeframe for making a determination would be detrimental to the Member's life or health, or could jeopardize Member's ability to regain maximum function; [83] or

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

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

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

[81] DHCS APL 21-011
[82] CA Health & Saf. Code § 1367.01
[83] CA Health & Saf. Code § 1367.01(h)(2)

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

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

Delegate must notify both the Provider and Member utilizing the IEHP-approved "Notice of Action" template and provide "Your Rights" attachment with all denials that instructs a Member or Member's representative about the appeal/grievance process. See the section on "Notification Requirements" within this policy.

If accepted as an urgent pre-service or urgent concurrent request, the Delegate must render a decision and notify the Member and Provider as expeditiously as the Member's health condition requires but no more than regulatory timeframes (see "UM Timeliness Standards – Medi-Cal" found on the IEHP website[84]).

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

1) If a request for retrospective review is received more than one hundred twenty (120) calendar days after the date that the service was rendered, 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.[85] If medical necessity is not met, denial determinations must be made by the Delegate Medical Director.[86]

3) Both the Member and Provider must be notified of post-service (retrospective review) determinations,[87] using the appropriate "Notice of Action" template. In case of a denial or partial approval of post-service requests, IEHP recommends the following language: "Your Provider's request to approve the services you already received on <MM/DD/YYYY> does not meet the criteria and is not medically necessary. Please note that, as the Member, you are not responsible for paying for any of these services. If you receive a bill from your Provider, please inform <IPA Name> immediately by calling Member Services

[84] https://www.iehp.org/en/providers/provider-resources?target=forms
[85] NCQA, 2023 HP Standards and Guidelines, UM 6, Element A
[86] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[87] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.2, Timeframes for Medical Authorization

at <IPA Contact Information, including TTY>." See the section on "Notification Requirements" within this policy.

g. The timeframes for rendering decisions and sending notifications to the Provider and Member are outlined in this Provider Manual (See "UM Timeliness Standards – Medi-Cal" found on the IEHP website[88]). These timeframes allow the Member sufficient time to request Aid Paid Pending, if applicable.

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 through IEHP's secure 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 or tertiary facility to a contracted or capitated Provider, the Delegate must first verify and document the following:

   a. That the redirected Provider is of the same discipline and able to provide equivalent service dependent on the Member's medical condition; and

   b. That the Member can receive services within IEHP's access standards. Please see Policy 9A, "Access Standards" for more information.

   Documentation of the above must include:

   a. Name and title of contact at Provider's office;

   b. Date of outreach;

   c. Expected date of Member's appointment; and

   d. Confirmation that the Provider is of the same discipline and able to provide equivalent service dependent on the Member's medical condition.

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

9. **Notification Requirements**: Any decision to deny a service authorization based on medical necessity or to authorize a service that is less than requested in an amount, duration, or scope must be reviewed and approved by the Delegate Medical Director or physician designee.[89,90,91] Members and Providers must receive denial letters for any requested referral that is denied or modified.[92]

    a. All IEHP-approved notification templates are available online at www.iehp.org. The Delegate is responsible for ensuring they are utilizing the most recent version of the template. Notices of Action must adhere to the following:

        1) Include required DMHC language (in bold within template online);

        2) Include required DHCS language;

        3) Written in a manner, format, and language that can be easily understood; [93,94]

        4) Fully translating the Notice of Action including the clinical rationale for the health plan's decision, in the Member's required language;[95]

        5) 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;[96]

        6) Include the right to appeal the decision, file a grievance, ask for an Independent Medical Review (IMR), refer to "Your Rights;"[97,98,99,100]

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

            - Medical necessity denials must cite the criteria used and the reason why the clinical information did not meet criteria;[101,102,103]

[89] CA Health & Saf. Code § 1367.01
[90] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[91] NCQA, 2023 HP Standards and Guidelines, UM 4, Element A
[92] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.1.5, Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests
[93] NCQA, 2023 HP Standards and Guidelines, UM 7, Element B, Factor 1
[94] NCQA, 2023 HP Standards and Guidelines, UM 7, Element E, Factor 1
[95] DHCS APL 21-011
[96] NCQA, 2023 HP Standards and Guidelines, UM 7, Element E, Factor 1
[97] CA Health & Saf. Code § 1367.01
[98] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.6.3, Notice of Action
[99] NCQA, 2023 HP Standards and Guidelines, UM 7, Element C
[100] NCQA, 2023 HP Standards and Guidelines, UM 7, Element F
[101] CA Health & Saf. Code § 1367.01
[102] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1 Prior Authorizations and Review Procedures
[103] DHCS APL 21-011

- Non-covered benefit denials must cite the specific provision in the Evidence of Coverage (EOC) (i.e., the IEHP Member Handbook), Medi-Cal Provider Manual or State or Federal regulations that exclude that coverage including the section. Non-covered benefits cannot be solely based on a code not being covered;
- Information on how the Member and Provider can obtain the utilization criteria or benefits provision used in the decision;[104]
- Member-specific denial language should be at a readability level of 6th grade[105] and should not include CPT Codes and abbreviations; and

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

b. The written communication to a Provider of a denial based on medical necessity must include the name and telephone number of the UM Medical Director or physician designee responsible for the denial.[106] Such communication must offer the requesting Provider the opportunity to discuss with the physician reviewer any issues or concerns regarding the decision.[107] This written notification of denial or partial approval (modification) must include language informing the Provider of the appeal process. [108,109] See Section 16, "Grievance and Appeals Resolution System" for more information.

c. On a monthly basis, for monitoring purposes, the Delegate must send to IEHP all documentation for each denial including the following. Please see Policy 25E2, "Utilization Management – Reporting Requirements" for more information.
   1) Referral Universe;
   2) Letters and attachments;
   3) Clinical documentation;
   4) Referral;
   5) Outreach/call logs, if any
   6) Supporting evidence of the following:
      - Received Date;
      - Decision Date and Time;

[104] NCQA, 2023 HP Standards and Guidelines, UM 7, Element B, Factor 3
[105] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.1.3, Member Information
[106] CA Health & Saf. Code § 1367.01
[107] NCQA, 2023 HP Standards and Guidelines, UM 7, Element A
[108] NCQA, 2023 HP Standards and Guidelines, UM 7, Element C
[109] NCQA, 2023 HP Standards and Guidelines, UM 7, Element F

- RN/LVN or physician reviewer note from medical management system; and
- Proof of date and time letter was mailed to the Member

7) Criteria used for the determination
8) Initial notification including opportunity to discuss; and
9) Audit trail to include all changes and dates made to the case.

Over and Under Utilization Monitoring

A. Delegates must collect, report, and analyze UM data related to Members for potential over or under utilization.[110]
   1. UM data reported includes, at a minimum, the following:
      a. Enrollment;
      b. Re-admits within thirty (30) days of discharge;
      c. Total number of prior authorization requests;
      d. Total number of denials;
      e. Denial percentage;
      f. Emergency encounters; and
      g. Disease-specific over and under utilization metrics.
   2. Delegate must present the above data in summary form to its UM Committee for review and analysis at least quarterly;
   3. Delegates must present selected data from above to its PCPs, Specialists, and/or Hospitals as a group, e.g., Joint Operations Meetings (JOMs), or individually, as appropriate; and
   4. Delegates must be able to provide evidence of review of data above by its UM Committee for trends by physician for both over-utilization and under-utilization.

Other UM Program Requirements

A. **Referral Requests:** PCPs are responsible for supervising, coordinating, and providing initial primary care to patients; for initiating referrals; for maintaining the continuity of patient care, and for serving as the Medical Home for Members.[111] 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."

[110] DHCS-IEHP Primary Operation Contract, Exhibit A, Attachment III, Provision 2.3.3, Review of Utilization Data
[111] DHCS-IEHP Primary Operations Contract, Exhibit E, Attachment I, Definitions

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.[112,113] Please see Policy 12A2, "Coordination of Care – Continuity of Care."

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 specialty care center for a Member who has a life threatening, degenerative, or disabling condition that requires coordination of care by a Specialist.[114,115] Delegates must have a system in place to track open, unused, and standing referrals. Please see Policy 14A2, "Standing Referral and Extended Access to Specialty Care" for more information.

D. **Second Opinions:** IEHP provides for its Members second opinion from a qualified health professional within the network at no cost to the Member or arranges for the Member to obtain a second opinion outside of the network, if services are not available within the network.[116,117] Refer to Policy 14B, "Second Opinions," for more information.

E. **Vision Services**: IEHP is responsible for utilization management associated with vision services for Medi-Cal Members.

F. **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.

G. **Communication Services**: IEHP and its Delegates must provide access to staff for Members and Providers seeking information about the UM process and the authorization of care by providing these communication services: [118]

1. IEHP and its Delegates shall maintain telephone access for Providers to request authorization for healthcare services.[119]

2. IEHP and its Delegates' UM staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.[120] Communications received after normal business hours will be returned on the next business day.

[112] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.12, Continuity of Care
[113] DHCS All Plan Letter (APL) 22-032 Supersedes APL 18-008, "Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, and for Medi-Cal Members who Transition Into a New Medi-Cal Managed Care Health Plan on or After January 1, 2023"
[114] DHCS-IEHP Primary Operations Contract, Attachment III, Provision 2.3, Utilization Management Program
[115] CA Health & Saf. Code § 1374.16
[116] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program
[117] NCQA, 2023 HP Standards and Guidelines, MED 1, Element C
[118] NCQA, 2023 HP Standards and Guidelines, UM 3, Element A, Factors 1 through 5
[119] CA Health & Saf. Code § 1367.01
[120] NCQA, 2023 HP Standards and Guidelines, UM 3, Element A, Factor 1

3. Outbound communication from staff regarding inquiries about UM are made during normal business hours;
4. Staff identify themselves by name, title, and organization when initiating or returning calls regarding UM issues.[121]
5. Staff can receive inbound communication regarding UM issues after normal business hours.
6. There is a toll-free TDD/TTY service for Members who are deaf, hard-of-hearing, or speech-impaired.[122]
7. Language assistance is available for IEHP Members to discuss UM issues.[123]

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

H. **Rescinding or Modifying Authorization** - Any authorization provided by a Delegate must not be rescinded or modified after the Provider has already rendered the health care service in good faith pursuant to the authorization.[124]

I. **Record Retention:** Delegates shall retain information on decisions, e.g., authorizations, denials or partial approvals (modifications) for a minimum period of ten (10) years. [125]

J. **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.[126]

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

[121] NCQA, 2023 HP Standards and Guidelines, UM 3, Element A, Factor 3
[122] NCQA, 2023 HP Standards and Guidelines, UM 3, Element A, Factor 4
[123] NCQA, 2023 HP Standards and Guidelines, UM 3, Element A, Factor 5
[124] CA Health & Saf. Code § 1371.8
[125] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 3.1.6, Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements
[126] NCQA, 2023 HP Standards and Guidelines, UM 1, Element A, Factor 6

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 a procedure in place to log requests by date and receipt of information so that timeframes and compliance with those timeframes can be tracked. Delegate documentation of authorizations or referrals must include, at a minimum: Member name and identifiers, description of service or referral required, medical necessity to justify service or referral, place for service to be performed or name of referred physician, and proposed date of service. Delegate documentation must also include a written assessment of medical necessity, relevant clinical information, appropriateness of level of care, and the specific criteria upon which the decision was based. Any denial of a proposed service or referral must be signed by Medical Director or physician designee.
4. **Member Access to Documentation:** Members may request, free of charge, copies of all documents and records the Delegate relied on to make its decision, including any clinical criteria or guidelines used.[127]

K. **Inpatient Stay**: If delegated to perform inpatient utilization management activities, the process must include:

1. Determining medical necessity;
2. Determining appropriate level of care;
3. Coordinating with hospital Case Manager's discharge plan.

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

L. **Discharge Planning:** If delegated to perform inpatient utilization management activities, the process must include coordination of care with IEHP and facilities and the following activities related to discharge planning:

1. Arranging necessary follow-up care (home health, follow-up PCP or specialty visits, etc.); and
2. 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.

M. **Repatriation:** Delegates must assist with the transfer of Members, as medically appropriate, back into the IEHP network during an inpatient stay, as applicable.

N. **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

[127] 42 CFR § 438.404(b)(2)

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.

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

P. **Affirmative Statement Regarding Incentives:** UM decisions for Members must be based only on appropriateness of care and service and existence of coverage. [128] Delegates do not provide specifically reward Practitioners or other individuals conducting utilization review for issuing denials of coverage or service.[129] Delegates ensure that contracts with physicians do not encourage or contain financial incentives for denial or underutilization of coverage or service.[130] The Affirmative Statement about incentives is distributed annually to all Practitioners, Providers, and employees involved in authorization review, as well as Members.

Q. **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 this evaluation and ensure that decisions are rendered, unhindered by fiscal and administrative management.[131]

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

Grievance and Appeals Process

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

B. A Member or Provider who is not able to obtain a timely referral to an appropriate Provider can file a complaint with the DMHC:[132]

   1. Member complaint line: By phone toll-free at (888)466-2219

[128] NCQA, 2023 HP Standards and Guidelines, MED 9, Element E, Factor 1
[129] NCQA, 2023 HP Standards and Guidelines, MED 9, Element E, Factor 2
[130] NCQA, 2023 HP Standards and Guidelines, MED 9, Element E, Factor 3
[131] CA Health & Saf. Code § 1367.02
[132] CA Health & Saf. Code § 1367.031(e)(2)(C)

By email at helpline@dmhc.ca.gov

2. Provider complaint line: By phone toll-free at (877)525-1295
   By email at plans-providers@dmhc.ca.gov

Monitoring Activities and Oversight

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

1. **Delegation Oversight Audits (DOA)** – IEHP performs a Delegation Oversight Audit of its Delegates' UM program and objectives, policies, procedures, activities and their progress. This audit re-assesses the Delegates' operational capabilities in the areas of UM and other delegated activities. Please refer to Policy 25A1, "Delegation Oversight Audit" for further details.

2. **Analysis of Provider Data Reports** – Through its delegation oversight process, IEHP reviews health plan and Delegate reports and utilization data including second opinion tracking logs, referral universes and letters, annual and semi-annual work plans. Provider reports and utilization data is subsequently reviewed by the Delegation Oversight Committee (DOC).

3. **Review of Approvals and Denials** – IEHP and its Delegates are required to submit a monthly Referral Universe from which authorizations are selected for review. Please refer to Policy 25E2, "Utilization Management – Reporting Requirements" for more information.

4. **Focused Referral and Denial Audits:** IEHP performs focused audits of the referral and denial process for Delegates. Please refer to Policy 25E3, "Referral and Denial Audits." Audits examine source data at the Delegate to determine referral process timelines and appropriateness of denials and the denial process, including denial letters.

5. **Member or Provider Grievance Review:** IEHP performs review, tracking, and trending of Member or Provider grievances and appeals related to UM. IEHP reviews Delegate grievances and recommended resolutions for policies, procedures, actions, or behaviors that could potentially negatively impact Member health care.

6. **Joint Operations Meetings (JOMs):** JOMs are intended to provide a forum to discuss issues and ideas concerning care for Members. They allow IEHP a method of monitoring plan administration responsibilities delegated to Delegates. JOMs may address specific Provider Experience, UM, QM, CM, grievance, study results, or any other pertinent quality issues affecting Providers, Hospitals or Delegates. They are held with Delegates and Hospital partners, as applicable. These meetings are designed to address issues from an operational level.

7. **Satisfaction with the UM Process**: At least annually, IEHP performs Member and Provider Experience Surveys as a method for determining barriers to care and/or satisfaction with IEHP processes including UM.

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

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14. UTILIZATION MANAGEMENT

A. Review Procedures

1. Primary Care Provider Referrals

APPLIES TO:

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

POLICY:

A. Primary Care Providers (PCPs) are responsible for supervising, coordinating, and providing initial primary care to patients; for initiating referrals; and for maintaining the continuity of patient care, and for serving as the Medical Home for Members.[1]

B. IEHP and its Delegates must have a referral system to track and monitor referrals requiring prior authorization for the program of Utilization Management program oversight.[2] See Policy 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."

[1] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment I, Definitions

[2] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program

C. Copies of referrals and any received consultations and/or service reports must be filed in the Member's medical record.[3]

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

D. PCPs must maintain a Referral Tracking Log or another referral tracking system for all referrals submitted for approval to IEHP or their IPA. PCPs must utilize this log or tracking system 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[4]) 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));[5]
10. Date of appointment or service;
11. Date the consult report was received; and/or

[3] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 1.1.9, Administrative Duties/Responsibilities
[4] https://www.iehp.org/en/providers/provider-resources?target=forms
[5] CA Health & Saf. Code § 1374.16(c)

12. Outreach efforts (dates of when outreach was attempted).

F. The PCP Referral Tracking Log or equivalent must always be available at the PCP site. This is reviewed during Facility Site Review and Medical Record Review Survey, Interim Audits, and/or Focused Audits, or as required in accordance with Policy 7A, "PCP and IPA Medical Record Requirements."

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

H. For referrals for behavioral health services, please see policies 12K1, "Behavioral Health - Behavioral Health Services" and 12K2, "Behavioral Health - Alcohol and Drug Treatment Services."

I. Monitoring and Oversight

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

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

3. IEHP will also issue a Corrective Action Plan (CAP) 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 IHEP website[6]).

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[6] 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 Medi-Cal Members.

POLICY:

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

B. PCPs are responsible for supervising, coordinating and providing initial and primary care to Members; for initiating referrals; and for maintaining continuity of care.[2]

PROCEDURES:

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

1. Contacting IEHP Member Services Department at (800) 440-4347 or TTY (800) 718-4347; or
2. Accessing Doctor Search online at www.iehp.org.

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

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

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

[1] California Health and Safety Code (Health & Saf. Code) § 1374.16
[2] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment I, Provision 1.0, Definitions

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

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

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

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

1. The PCP submits the request for standing referral to the Member's IPA using the designated form (See "Standing Referral/Extended Access Referral to Specialty Care" found on the IEHP website[3]).
2. Within three (3) business days of receiving this request, IEHP or the IPA must:[4,5]
   a. Consult with the PCP, Specialist (if any) and/or Member to ascertain the need for continuing care with the Specialist;
   b. Approve a treatment plan (if necessary to describe the course of care); and
   c. Make a determination to approve, deny or partially approve (modify) the standing referral request. Determinations must be made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and

[3] https://www.iehp.org/en/providers/provider-resources?target=forms
[4] CA Health & Saf. Code § 1374.16(c)
[5] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program

Providers. See Policy 25E1, "Utilization Management – Delegation and Monitoring."

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

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

G. When authorizing a standing referral to a Specialist for the purpose of the diagnosis or treatment of a condition requiring care by a Physician with a specialized knowledge of HIV medicine, the Member must be referred to an HIV/AIDS Specialist.[8] When authorizing a standing referral to a Specialist for purposes of having that Specialist coordinate the care of a Member, who is infected with HIV, the Member must be referred to an HIV/AIDS Specialist.[9]

Out of Network

A. IEHP and its IPAs must 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.[10,11]

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.[12]

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[6] CA Health & Saf. Code § 1374.16(c)
[7] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program
[8] Title 28, California Code of Regulations § 1300.74.16(f)
[9] Ibid.
[10] CA Health & Saf. Code § 1342.72
[11] Department of Managed Health Care (DMHC) All Plan Letter (APL) 22-030, "Requirement for Plans to 'Arrange for' Covered Services"
[12] 28 CCR § 1300.74.16(g)

14. UTILIZATION MANAGEMENT

A. Review Procedures
3. Other Health Coverage

APPLIES TO:

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

POLICY:

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

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

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

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

DEFINITIONS:

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

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

PROCEDURES:

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

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

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

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

[1] California Welfare and Institutions Code (Welf. & Inst. Code) § 14124.90
[2] Title 22, California Code of Regulations (CCR) § 50763(a)(3)
[3] Title 42, United States Code §1396a(a)(25)(D)
[4] Department of Health Care Services (DHCS) All Plan Letter (APL) 22-027 Supersedes Policy Letter (PL) 21-002, "Cost Avoidance and Post-Payment Recovery for Other Health Coverage"

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

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

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

E. For IEHP and its Delegates to consider benefit coverage, proof that all sources of payment have been exhausted must be documented, or the service meets the requirement for billing Medi-Cal directly. Acceptable forms of such proof include:[5]

1. A denial letter from the OHC for the service;
2. An explanation of benefits indicating that the service is not covered by the OHC; or
3. Documentation that the provider has billed the OHC and not received a response within 90 days.

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

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

Monitoring and Oversight

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

[5] DHCS APL 22-027
[6] 22 CCR § 1300.71

14. UTILIZATION MANAGEMENT

A. Review Procedures
   3. Other Health Coverage

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☒ DMHC	☐ NCQA
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14. UTILIZATION MANAGEMENT

B. Second Opinions

APPLIES TO:

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

POLICY:

A. IEHP and its IPAs provide for Member's second opinion from a qualified health professional within the network at no cost to the Member or arranges for the Member to obtain a second opinion outside of the network, if services are not available within the network.[1,2,3]

PROCEDURES:

Requesting Second Opinion

A. Primary Care Providers (PCPs), 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 should request a second opinion through their PCP or Specialist. If the PCP or Specialist refuses to submit a request for a second opinion, the Member can submit a grievance or a request for assistance through IEHP Member Services at (800) 440-4347. IEHP's Member Services staff directs the Member to their IPA to request a second opinion.

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

Timeframes

A. Determinations must be made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Providers. 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 seventy-two (72) hours of receiving the request, whenever possible.[4]

Authorizing Second Opinion Requests

A. Reasons for providing or authorizing a second opinion include, but are not limited to, the

[1] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, , Exhibit A, Attachment III, Provision 2.3, Utilization Management
[2] California Health and Safety Code (Health & Saf. Code) § 1383.15
[3] National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, MED 1, Element C
[4] CA Health & Saf. Code § 1383.15(c)

following:[5]

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

B. If the Member is requesting a second opinion about care received from their PCP, the second opinion must be provided by an appropriately qualified Provider of the Member's choice within the IPA's network.[6,7]

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.[8,9]

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.[10,11]

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

F. IEHP and its IPAs require the second opinion Provider to provide to the Member and initial Provider consultation reports, including any recommended procedures or tests that the second opinion Provider believes appropriate.[13] Consultation reports must be provided as expeditiously as the Member's condition requires, but not to exceed two (2) weeks of a non-

[5] CA Health & Saf. Code § 1383.15(a)
[6] CA Health & Saf. Code § 1383.15(e)
[7] NCQA, 2023 HP Standards and Guidelines, MED 1, Element C
[8] CA Health & Saf. Code § 1383.15(f)
[9] NCQA, 2023 HP Standards and Guidelines, MED 1, Element C
[10] CA Health & Saf. Code § 1383.15(g)
[11] NCQA, 2023 HP Standards and Guidelines, MED 1, Element C
[12] CA Health & Saf. Code § 1383.15(g)
[13] CA Health & Saf. Code § 1383.15(h)

urgent visit or twenty-four (24 hours) of an urgent visit.

G. Behavioral Health (BH) Providers who complete a second opinion evaluation or consultation must submit the "BH Initial Evaluation Coordination of Care Report" to the IEHP Behavioral Health and Care Management Department through the secure IEHP Provider portal as expeditiously as the Member's condition requires, but no later than two (2) weeks of a non-urgent visit or twenty-four (24) hours of an urgent visit. BH Providers can receive training on how to use the secure IEHP Provider portal or how to complete the provider web forms by calling the IEHP Provider Relations Team at (909) 890-2054 or emailing providerservices@iehp.org.

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

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

J. A request for second opinion may only be denied if the Member insists on an out-of-network provider when there is an appropriately qualified Provider in-network. If the request for second opinion is denied, the IPA provides written notification to the Member, including the rationale for the denial, alternative care recommendations, and information on how to appeal this decision.[14]

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" found on the IEHP website[15]). Please see Policy 14A1, "Review Procedures – Primary Care Provider Referrals" for more information.

B. IPAs must utilize a Second Opinion Tracking Log to track the status of second opinion requests and to ensure that the second opinion Provider provides the consultation report within the timeframes described in this policy (See "Second Opinion Tracking Log" found on the IEHP website[16]). See Policy 25E2, "Utilization Management - Reporting Requirements" for more information.

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

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

14. UTILIZATION MANAGEMENT

B. Second Opinions

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☒ DMHC	☐ NCQA
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14. UTILIZATION MANAGEMENT

C. Emergency Services

APPLIES TO:

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

POLICY:

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

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

C. IEHP covers Emergency Medical Transportation (EMT) services necessary to provide access to all emergency covered services, including emergency mental health services.[7]

DEFINITIONS:

A. Emergency medical condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:[8,9,10,11]

   1. Placing the health of the individual (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

   2. Serious impairment to bodily function; or

[1] Title 22 California Code of Regulations § 53855(a)
[2] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 3.3.16, Emergency Services and Post-Stabilization Care Services
[3] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.2, Timeframes for Medical Authorization
[4] National Committee for Quality Assurance (NCQA), 2023 Health Plan (HP) Standards and Guidelines, MED 9 Element D, Factor 1
[5] DHCS All Plan Letter (APL) 22-005, "No Wrong Door for Mental Health Services Policy"
[6] DHCS APL 23-009, Authorizations for Post-Stabilization Care Services
[7] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.7 Services for All Members
[8] Title 42, Code of Federal Regulations (CFR) § 438.114
[9] California Health and Safety Code (Health & Saf. Code) § 1317.1(b)
[10] NCQA, 2023 HP Standards and Guidelines, MED 9 Element D, Factor 1
[11] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment I, Provision 1.0, Definitions

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:[12]

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

C. Emergency services – Covered inpatient and outpatient services that are furnished by a Provider qualified to furnish such services and that are needed to evaluate or stabilize a Member's emergency medical condition.[13] This includes all professional, physical, mental, and substance use treatment services, screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medication exists, for all services medically necessary to stabilize the Member.

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

PROCEDURES:

A. Healthcare professionals must have internal policies and procedures that delineate what steps are to be taken in the event a Member presents to their office with a medical or psychiatric emergency requiring immediate intervention. These steps should include when office staff or Practitioners should call 911. Providers need to ensure all office staff and Practitioners are trained on how to handle these types of emergencies.[14]

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

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

[12] CA Health & Saf. Code § 1317.1(k)
[13] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment I, Provision 1.0, Definitions
[14] https://www.aafp.org/afp/2007/0601/p1679.html

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

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

Post-Stabilization Care

A. The attending emergency physician or treating Provider is responsible for determining when the Member is sufficiently stabilized for transfer or discharge.[15,16]

B. IEHP ensures that a physician is available twenty-four (24) hours a day, seven (7) days a week to authorize medically necessary post-stabilization care and coordinate the transfer of stabilized Members in an ED, if necessary.[17,18]

C. IEHP shall make every effort to respond to requests for necessary post-stabilization medical care within thirty (30) minutes of receipt.

D. IEHP is financially responsible for post-stabilization care services in the event that the Plan: [19,20,21,22]

1. Does not respond to a request for pre-approval within the timeframe allotted;
2. Cannot be contacted; or
3. Cannot reach an agreement with the treating Provider concerning the Member's care and a Plan physician is not available for consultation.

All subsequent days are subject to review for medical necessity.

E. IF IEHP is unable to reach an agreement with the attending emergency physician regarding the Member's care, the attending emergency physician may continue with care for the

[15] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 3.3.16, Emergency Services and Post-Stabilization Care Services
[16] NCQA, 2023 HP Standards and Guidelines, MED 9 Element D, Factor 3
[17] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 3.2.6, Emergency Department Protocols
[18] NCQA, 2023 HP Standards and Guidelines, MED 9 Element D, Factor 2
[19] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization
[20] Title 28, California Code of Regulations (CCR) § 1300.71.4(b)
[21] NCQA, 2023 HP Standards and Guidelines, MED 9 Element D, Factor 3
[22] DHCS APL 23-009

Member until an IEHP physician is able to be consulted and one of the following criteria is met.[23]

1. An IEHP physician with privileges at the emergency physician's hospital assumes responsibility for the Member's care;
2. An IEHP physician assumes responsibility for the Member's care through transfer;
3. The IEHP physician and the attending emergency physician are able to reach an agreement concerning the Member's care; or
4. The Member is discharged.

F. All requests for authorization of post-stabilization care services are documented in IEHP's medical management system along with any responses to such requests. Documentation includes, but is not limited to, the date and time of the request, the name of the requesting Provider, and the name of the IEHP representative responding to the request.

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

H. If IEHP denies the request for authorization of post-stabilization medical care and elects to transfer the Member to another health care provider, IEHP informs the provider of the health plan's decision and coordinates the transfer of the Member.[24]

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

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.[25]

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Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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[23] DHCS APL 23-009
[24] 28 CCR § 1300.71.4(c)
[25] CA Health & Saf. Code § 1262.8(j)

14. UTILIZATION MANAGEMENT

D. Pre-Service Referral Authorization Process

APPLIES TO:

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

POLICY:

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

B. Primary Care Providers (PCPs) are responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care, and for serving as the Medical Home for Members.[2]

DEFINITIONS:

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

PROCEDURES:

Provider Responsibilities

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

1. Designation of the referral request as either routine or expedited to define the priority of the response.
    a. Referrals that are not prioritized are handled as "routine."
    b. Referrals that are designated as "expedited" must include the supporting documentation regarding the reason the standard timeframe for issuing a determination could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function;[3]
2. The diagnosis (ICD) and procedure (CPT) codes;
3. Pertinent clinical information supporting the request; and
4. Signature of referring Provider and date. This may consist of handwritten signature,

[1] California Health and Safety Code (Health & Saf. Code) § 1367.01
[2] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment I, Definitions
[3] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provisions 2.3.2, Timeframes for Medical Authorization

handwritten initials, unique electronic identifier, or electronic signatures that can demonstrate appropriate controls to ensure that only the individual indicated may enter a signature.

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

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

D. Specialists are required to forward consultation notes to the referring Provider within two (2) weeks of the visit. Copies of referrals and any received consultations and/or service reports must be filed in the Member's medical record.[4] See Policy 14A1, "Primary Care Provider (PCP) Referrals."

IEHP and Delegate Responsibilities

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

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

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

1. Verification of Member eligibility by the Delegate;
2. Verification of presence of other health coverage (see Policy 14A3, Review Procedures – Other Health Coverage);
3. Written documentation by the referring Provider of medical necessity for a service, procedure, or referral;
4. Verification by the Delegate that the place of service and requested Provider is within the IEHP network;
5. Assessment of medical necessity and appropriateness of level of care with determination of approval or denial of the proposed service or referral;
6. Consulting with the referring Provider, when appropriate.[6]

[4] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 1.1.9, Administrative Duties/Responsibilities
[5] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management
[6] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures

C. IEHP and its Delegates consistently apply criteria and standards for approving, partially approving (modifying or authorizing an amount, duration or scope that is less than requested), or denying requested services.[7] See Policy 25E1, "Utilization Management – Delegation and Monitoring."

D. IEHP and its Delegates ensure that decisions to deny or partially approve (modify) are made by a qualified health care professional with appropriate clinical expertise in the condition and disease.[8] Please see Policy 25E1, "Utilization Management – Delegation and Monitoring."

E. IEHP and its Delegates must have a process that facilitates the Member's access to needed specialty care by prior authorizing, at a minimum, a consult and up to two (2) follow up visits for medically necessary specialty care. Prior authorization for medically necessary procedures or other services that can be performed in the office, beyond the initial consultation and up to two (2) follow up visits, should be authorized as a set or unit. For example, when approving an ENT consultation for hearing loss, an audiogram should be approved (See "Specialty Office Service Auth Sets Grid" found on the IEHP website[9]).

F. IEHP and its Delegates must have a process in place to allow a Specialist to directly request authorization from IEHP or the Delegate for additional specialty consultation, diagnostic, or therapeutic services. [10]

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

1. Emergency services (see Policy 14C, "Emergency Services");[11,12,13]
2. Family planning (see Policy 10G, Family Planning Services"); [14,15, 16]
3. Abortion services (see Policy 9E, "Access to Services with Special Arrangements");[17]

[7] Ibid.
[8] Ibid.
[9] https://www.iehp.org/en/providers/provider-resources?target=forms
[10] CA Health & Saf. Code § 1367.01
[11] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[12] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.2, Timeframes for Medical Authorization
[13] National Committee for Quality Assurance (NCQA), 2023 Health Plan (HP) Standards and Guidelines, MED 9, Element D, Factors 1 through 3
[14] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[15] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.1.1, Member Rights and Responsibilities
[16] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[17] DHCS APL 22-022 Supersedes APL 15-020, "Abortion Services"

4. Sexually transmitted infection (STI) diagnosis and treatment (see Policy 10H, "Sexually Transmitted Infection (STI) Services"); [18,19]
5. Sensitive and confidential services (see Policy 9E, "Access to Services with Special Arrangements");
6. HIV testing and counseling at the Local Health Department (See Policy 10I, HIV Testing and Counseling"); [20,21]
7. Immunizations at the Local Health Department (See Policy 10I, HIV Testing and Counseling");[22]
8. Routine OB/GYN Services, (including prenatal care by Family Care Practitioner (credentialed for obstetrics) within IEHP network;[23]
9. Out of area renal dialysis;[24]
10. Biomarker testing for advanced or metastatic stage 3 or 4 cancers;[25,26]
    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.[27]
11. Initial mental health and substance use disorder (SUD) assessments;[28]
12. Urgent care;[29] and

[18] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[19] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[20] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[21] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[22] DHCS All Plan Letter (APL) 18-004 Supersedes Policy Letter (PL) 96-013 and APL 07-015, "Immunization Requirements"
[23] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[24] DHCS Medi-Cal Provider Manual, "Dialysis: End Stage Renal Disease Services"
[25] California Health and Safety Code (CA HSC) §1367.665
[26] DHCS APL 22-010 "Cancer Biomarker Testing"
[27] https://www.accessdata.fda.gov/scripts/cder/daf/
[28] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[29] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.5, Network Adequacy Standards

13. Preventive services,[30,31] which includes those listed in the Department of Health Care Services (DHCS) Medi-Cal Provider Manual- Preventive Services List,[32] as well as the following:
    a. Bone Density Screening (CPT codes: 77080 and 77081)
    b. Diagnostic Mammograms for ages 40 and above (CPT codes: 77065, 77066 and 77063)
    c. Lung Cancer Screening (CPT codes: S8032 and 71271)

H. IEHP will accept only the listed request types for continued services from contracted Durable Medical Equipment (DME) vendors. Approval will be based on medical guidelines and frequency limitations.
    1. Oxygen supplies, they must have oxygen saturation levels on room air annually;
    2. CPAP/BiPAP supplies;
    3. Ostomy supplies;
    4. Incontinent supplies;
    5. Non disposable insulin pump supplies;
    6. Enteral/Parenteral feeding pump supplies;
    7. TENS unit supplies; and
    8. Suction canisters.

I. Referrals to out-of-network practitioners require documentation of medical necessity, rationale for the requested out-of-network referral, and prior authorization from the IPA (see "Health Plan Referral Form for Out-of-Network and Special Services" found on the IEHP website[33]). Once the prior authorization has been obtained, the PCP's office should assist the Member with making the appointment, continue to monitor the Member's progress to ensure appropriate intervention and safe transition back into the network.

J. IEHP and its Delegates must authorize access to out-of-network providers in instances, including but not limited to the following:
    1. The Plan does not meet network adequacy standards;[34]
    2. The Plan does not have Alternative Access Standards approved by DHCS and does not meet network adequacy standards;

[30] Title 45 Code of Federal Regulations (CFR) 147.130 "Coverage of Preventive Health Services"
[31] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[32] https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/prev.pdf
[33] https://www.iehp.org/en/providers/provider-resources?target=forms
[34] CA Welfare and Institutions (Welf. & Inst.) Code § 14197

3. The Plan does not meet time or distance standards;
4. The Plan is unable to meet requirements for timely access to appointments; and
5. The Provider type is unavailable within the Plan's service area and within adjoining counties; and
6. The Plan does not have in-network Long Term Care capacity.

K. 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[35]).[36] See Policy 25E1, "Utilization Management - Delegation and Monitoring."

L. A Member or Provider who is not able to obtain a timely referral to an appropriate Provider can file a complaint with the Department of Managed Health Care (DMHC):[37]

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 the redirection of the Members' care, as needed.[38]

Monitoring and Oversight

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

1. Potential over or under utilization of Specialists;[39] and
2. Referral requests that are within the scope of practice of the PCP.

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

1. A written correspondence to the Provider that identifies the concern with supporting policy or contract attached;
2. An outreach from the Medical Director to discuss the concern and educate the Provider; or
3. Any other intervention deemed appropriate by the Medical Director, which may include but not be limited to reporting a potential quality of care incident and/or escalating the issue to the Peer Review Subcommittee.

[35] https://www.iehp.org/en/providers/provider-resources?target=forms
[36] Title 42 Code of Federal Regulations (CFR) §§ 438.210, 422.568, 422.570, and 422.572
[37] CA Health & Saf. Code § 1367.01(e)
[38] DHCS APL 21-003 Supersedes APL 16-001, "Medi-Cal Provider and Subcontractor Terminations"
[39] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.3, Review of Utilization Data

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14. UTILIZATION MANAGEMENT

E. Referral Procedure for Powered Mobility Devices

APPLIES TO:

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

POLICY:

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

DEFINITIONS:

A. Qualified Rehabilitation Professional – Professionals with competence in analyzing the needs of consumers with disabilities, assisting in the selection of appropriate assistive technology for the Member's needs, and training in the use of the selected device(s). Specialty certification in required for professionals working in seating, positioning and mobility.[3]

PROCEDURES:

IPA Responsibilities

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

B. Prior to the submission of a request to IEHP for the purchase of a powered mobility device, the IPA must ensure the Member undergoes a functional/safety evaluation performed by an independent third party to determine medical necessity. This evaluation must be performed by a Physiatrist or Qualified Rehabilitation Professional as authorized by the IPA.[4,5]

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

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

   2. The referral request must be accompanied with the following, at minimum:

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

a. Completed referral form signed by the Member's Physician or Specialist;

b. Information about the Member's current equipment, if applicable; and

c. The results of the functional/safety evaluation as performed by an independent third-party Physiatrist or Qualified Rehabilitation Professional.

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

IEHP Responsibilities

A. IEHP's UM department will review the referral and supporting documentation. Determinations are made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Providers (see "UM Timeliness Standards – Medi-Cal" found on the IEHP website[6]).[7] Please refer to Policy 25E1, "Utilization Management Delegation and Monitoring" for more information on timeliness standards.

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

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

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

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

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

[7] DMHC-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures

14. UTILIZATION MANAGEMENT

F. Long-Term Care (LTC)

1. Custodial Level and Intermediate Care Facilities/Developmentally Disabled (ICF/DD)

APPLIES TO:

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

POLICY:

A. IEHP ensures that Members in need of Long-Term Care (LTC) are placed in a health care facility that provides the level of care most appropriate to their medical needs. These health care facilities include but are not limited to skilled nursing, adult subacute, pediatric subacute, and intermediate care units, intermediate care facility for the developmentally disabled (ICF/DD), intermediate care facility for the developmentally disabled-habilitative (ICF/DD-H), and intermediate care facility for the developmentally disabled-nursing (ICF/DD-N).[1,2,3,4]

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

C. Financial responsibility for Medi-Cal Members under age 21 or residing in Intermediate Care Facilities for Developmentally Disabled (ICF-DD) continues to reside with IEHP.

PURPOSE:

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

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

DEFINITIONS:

A. Long-Term Care (LTC) – Rehabilitative, restorative and/or ongoing skilled nursing care to

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 17-017 Supersedes APL 03-003, "Long Term Care Coordination and Disenrollment"
[2] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.7, Services for All Members
[3] DHCS APL 23-023, "Intermediate Care Facilities for Individuals with Developmental Disabilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care"
[4] DHCS APL 23-027, "Subacute Care Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care"

patients or residents in need of assistance with activities of daily living.[5,6]

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.

C. Intermediate Care Facilities/Developmentally Disabled – Long-term home living setting for Members with intellectual or developmental disabilities who are eligible for services and supports through the Regional Center service system.

PROCEDURES:

Custodial Level Long Term Care and Provider Responsibilities

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

B. For Members directly admitted from the community, the treating Primary Care Provider (PCP) or Specialist must submit a referral to the Member's assigned IPA requesting admission. Determinations must be made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Practitioners (see "UM Timeliness Standards – Medi-Cal" found on the IEHP website[7]).[8] See Policy 14D, "Pre-Service Referral Authorization Process" for more information.

C. Within 48 hours of the Member's admission, the LTC facility must submit to the IEHP all clinical documentation that demonstrate the medical necessity of the inpatient admission, including the Preadmission Screening and Resident Review (PASRR)[9]. If clinical documents are not received timely, the inpatient admission will be at risk for potential denial.

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

[5] DHCS APL 23-027
[6] 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
[7] https://www.iehp.org/en/providers/provider-resources?target=forms
[8] Title 42 Code of Federal Regulations (CFR) §§ 438.210, 422.568, 422.570, and 422.572
[9] DHCS APL 23-004 Supersedes APL 22-018, "Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care"

3. For admissions from the community, GACH, or ICF/DD home: The Regional Center will work with the ICF/DD home to assist with the placement/transition process.[10]
    a. Level of Care Assessment is scheduled within two (2) weeks of admission to determine the appropriate level of care.
    b. The ICF/DD will contact IEHP to initiate authorization forms including Certification for Special Treatment Program Services form (HS 231) signed by the Regional Center, a Treatment Authorization Request form (LTC TAR, 201-1), and a Medical Review/ Prolonged Care Assessment (PCA) form (DHCS 6013A) or the information found on the PXCA form in any format (e.g., a copy of the Individual Program plan (IPP) or Individual Service Plan (ISP).

D. The LTC or ICF/DD facility must submit all clinical documentation in advance of, at the time of the Member's discharge, or at the latest, within two (2) business days post-discharge. If clinical documentation is not received timely, IEHP will issue a denial of payment to the facility due to lack of clinical documentation supporting medical necessity.
    1. Once IEHP receives clinical documentation for the ICF/DD home, the Nurse will provide the ICF/DD authorization with five (5) business days of receipt and communicate decision with the ICF/DD.[11]

E. Prior to transferring a Member to a hospital, or before a Member goes on therapeutic leave, the LTC or ICF/DD facility must provide written information to the Member or Member's representative that specifies:[12]
    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 or ICF/DD 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 or ICF/DD 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.[13]

F. If an LTC or ICF/DD 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.[14]

[10] DHCS APL 23-023
[11] Ibid.
[12] 42 CFR §483.15 (d)
[13] 42 CFR §483.15 (e)(1)
[14] 42 CFR §483.15 (e)(1)(ii)

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

IEHP, IPA & PCP Responsibilities

A. IPAs are responsible for forwarding to IEHP all requests for custodial level LTC or ICF/DD 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 must place Members in LTC facilities that are licensed and certified by California Department of Public Health (CDPH) and ensure that contracted LTC facilities have not been decertified by CDPH or otherwise excluded from participation in the Medi-Cal Program.[15]

C. IEHP and its IPAs provide all necessary care coordination for Members in LTC and ICF/DD 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, including Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT);[16,17]
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.

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

1. The criteria for admission are set forth in Title 22 of the California Code of Regulations Sections 51335, 51335.5, 51335.6, and 51334, and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in Title 22 of the California Code of Regulations.[18]

[15] DHCS APL 21-003 Supersedes APL 16-001, "Medi-Cal Network Provider and Subcontractor Terminations"
[16] DHCS APL 23-023
[17] DHCS APL 23-027
[18] DHCS APL 17-017

E. The determination of the appropriate level of care are based on the definitions set forth in the following sections of Title 22 of the California Code of Regulations:[19]

1. Skilled Nursing Facility - Section 51121
2. Subacute Level of Care - Section 51124.5
3. Pediatric Subacute Care Services - Section 51124, 51124.6
4. Intermediate Care Services - Section 51118, 51120
5. Nursing Facility – 51120.5

F. IEHP covers a Member stay in a facility with availability regardless of medical necessity if placement in a medically necessary appropriate lower level of care is not available. IEHP must coordinate with its IPAs to continue to attempt to place the Member in a facility with the appropriate level of care, including offering to contract with facilities within and outside of the service area.[20]

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

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

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

I. Concurrent review begins at admission and may be performed telephonically or onsite by chart review. Continued and subsequent reviews are performed using IEHP-approved authorization criteria. Please see Policy 25E1, "Utilization Management – Delegation and Monitoring."

1. Clinical progress notes must be received within two (2) business days of admission and at least every three (3) months until discharge, unless directed otherwise by the IEHP LTC Review Nurse.
2. Timely submission of clinical progress notes is required to determine whether continued stay at this level of care remains medically necessary. Therefore, untimely submission of clinical progress notes could result in denial of custodial days. IEHP will review and make

[19] Title 22 California Code of Regulations (CCR) § 51124
[20] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.7 Services for All Members

the best clinical decision possible based on the clinical documentation provided by the LTC facility (see "Long-Term Care (LTC) Initial Review Form" and "Long-Term Care (LTC) Follow-Up Review Form" which can be found on the IEHP website).[21]

3. Discharge planning should begin once the Member has been determined ready for lower level of care. IEHP must be informed of any discharge needs requiring authorization as soon as need is known but no later than prior to day of discharge (see "Service Request Form for Skilled Nursing Facilities" found on the IEHP website).[22]

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

K. IEHP must assess and estimate a length of stay for the Member as soon as possible after admission.

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

M. 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.

N. IEHP will authorize bed holds as follows:[23,24]

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 or ICF/DD facility that requested the hold in seven (7) calendar days, the bed hold will expire.
3. The LTC or ICF/DD 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 or ICF/DD facility.
5. If notified in writing by attending physician's the patient requires more than seven (7) days of hospitalization, the ICF/DD home is not required to hold the bed.

[21] https://www.iehp.org/en/providers/provider-resources?target=forms
[22] https://www.iehp.org/en/providers/provider-resources?target=forms
[23] DHCS Medi-Cal Provider Manual, "Leave of Absence, Bed Hold, and Room and Board"
[24] DHCS APL 23-023

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

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

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

P. Prior to being in custodial level LTC for ninety (90) calendar days, IEHP will request a copy of the completed MC171 form (if not already received) with the date it was submitted to the local agency (See "MC171 Form and Instruction 05-07" found on the DHCS website[25]).

Q. IEHP authorizes Leave of Absence (LOA) as follows:[26,27]

1. LOA will be authorized for up to seventy-three (73) days per calendar year for Members with developmental disabilities and eighteen (18) days per calendar year for all other Members. A physician signature is required for an LOA only when a Member is participating in a summer camp for the developmentally disabled.[28]

2. Up to twelve (12) additional days of LOA may be approved per calendar year in increments of no more than two (2) consecutive days. The additional days of LOA must be in accordance with the Member's care plan and appropriate to the mental and physical well-being of the Member.

3. At least five (5) days of LTC inpatient care must be provided between each approved LOA.

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

S. 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.

[25] https://www.dhcs.ca.gov/formsandpubs/forms/Pages/Index.aspx
[26] 22 CCR § 51535
[27] DHCS Medi-Cal Provider Manual, "Leave of Absence, Bed Hold, and Room and Board"
[28] DHCS APL 23-023

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

T. IEHP and the Member's IPA Care Manager are responsible for assessing whether a Member may be eligible for the Nursing Facility (NF) Waiver Program, in consultation with the Member's family, as necessary. IEHP or the Member's IPA facilitates the application for the waiver as outlined in Policy 12P, "Home and Community-Based Alternatives Waiver Program."

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

U. To best support Members' needs, IEHP utilizes its Long-Term Services and Supports (LTSS) Liaison to assist facilities in addressing claims and payment inquiries and assist with care transitions among the LTC Provider community:[29,30]

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

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

S. Effective January 1st, 2024, for Members residing in an ICF/DD and Subacute Care Facility who is transitioning from Medi-Cal fee-for-service (FFS) to IEHP, the following applies:

[29] DHCS APL 23-023
[30] DHCS APL 23-027

1. Adult and Pediatric Subacute Care Facilities:[31]
   a. IEHP will responsible for covering treatment authorization requests (TARs) that are approved by DHCS for Subacute Care services provided under the Subacute Care Facility per diem rate for a maximum period of six (6) months after enrollment into IEHP, or for the duration of the TAR, whichever is shorter. Subsequent reauthorizations may be approved for up to six (6) months.
   b. Reauthorizations may be approved for one (1) year for Members who have been identified or meet the criteria of "prolonged care."
2. ICF/DDs:[32]
   a. IEHP will honor TARs approved by DHCS, hereafter referred to as "authorization requests" for ICF/DD Home serves provided under the ICF/DD Home per diem rate for the duration of the treatment authorization for initial authorization may be granted for up to two (2) years from date of admission. Reauthorizations may be granted up to two (2) years.
   b. IEHP will honor all other DHCS-approved authorization requests for services in a ICF/DD Home, exclusive of the ICF/DD per diem rate for a period of 90 days after enrollment into IEHP, or until IEHP is able to reassess the Member and authorize and connect the Member to medical necessary services.

[31] DHCS APL 23-027
[32] DHCS APL 23-023

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14. UTILIZATION MANAGEMENT

F. Long Term Care
2. Skilled Level

APPLIES TO:

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

POLICY:

A. IEHP ensures that Members in need of Long-Term Care (LTC) are placed in a health care facility that provides the level of care most appropriate to their medical needs. These health care facilities include, but are not limited to, skilled nursing, adult subacute, pediatric subacute, and intermediate care units.[1,2]

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

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

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

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

PURPOSE:

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

DEFINITIONS:

A. Long-Term Care (LTC) – Rehabilitative, restorative and/or ongoing skilled nursing care to patients or residents in need of assistance with activities of daily living.[4]

B. Skilled Care – Medically necessary care that can only be provided by or under the supervision

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 17-017 Supersedes APL 03-003, "Long Term Care Coordination and Disenrollment"
[2] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.7, Services for All Members
[3] DHCS APL 17-017
[4] Ibid.

of skilled or licensed medical personnel. Examples include but are not limited to physical therapy, wound care, intravenous injections, and catheter care.[5]

PROCEDURES:

Skilled Level Long-Term Care and Provider Responsibilities

A. Primary Care Providers (PCPs) must evaluate a Member's need for skilled level LTC. A referral request must be submitted to the Member's IPA with sufficient medical information from the Member's PCP when transitioning from a community or usual setting. Determinations must be made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Practitioners (see Attachment, "UM Timeliness Standards – IEHP Medi-Cal" in Section 14).[6] See Policy 14D, "Pre-Service Referral Authorization Process."

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

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

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

[5] Centers for Medicaid and Medicare Services (CMS), "Custodial Care vs Skilled Care," March 2016. https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/infograph-CustodialCarevsSkilledCare-%5BMarch-2016%5D.pdf
[6] Title 42 Code of Federal Regulations (CFR) §§ 438.210, 422.568, 422.570, and 422.572

12H, "Community Based Adult Services (CBAS)" or child day care;

e. In-Home Supportive Services, see Policy 12F, "In-Home Supportive Services;"

f. Family education and training; and

g. Community networks and resources.

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

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

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

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

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

F. Unless directed otherwise by IEHP, the LTC facility must, on a weekly basis, inform IEHP of the expected outcome of the Member's health status. This includes but is not limited to clinical updates, status of goals, and discharge planning (See Attachments, "Long Term Care (LTC) Initial Review Form" and "Long Term Care (LTC) Follow-Up Review Form" in Section 14).

G. Prior to transferring a Member to a hospital, or before a Member goes on therapeutic leave, the LTC facility must provide written information to the Member or Member's representative that specifies:[8]

1. That the Member has a right to a seven (7) day bed hold, during which the Member is permitted to return and resume residence.

2. The LTC facility's policy regarding bed holds, consistent with the following:

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

a. If the Member's hospitalization or therapeutic leave exceeds the bed hold period of seven (7) days, but the Member still requires the services provided by the LTC facility and is still eligible for said services, the Member may still return to their previous room if available, otherwise they will be able to return immediately upon the first availability of a bed in a semi-private room.[9]

H. If an LTC facility determines that a Member who was transferred with an expectation of returning to the facility cannot return to the facility, the facility must follow the procedure for discharge in accordance with applicable state and federal requirements.[10]

I. The LTC facility must submit all clinical documentation in advance of, at the time of, or at the latest, within one (1) business day post-discharge. If clinical documentation is not received timely, IEHP will issue a denial of payment to the facility due to lack of clinical documentation supporting medical necessity.

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

IEHP, IPA and PCP Responsibilities

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

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

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

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

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

E. IEHP and its IPAs must place Members in LTC facilities that are licensed and certified by California Department of Public Health (CDPH) and ensure that contracted LTC facilities have not been decertified by CDPH or otherwise excluded from participation in the Medi-Cal

[9] 42 CFR §483.15 (e)(1)
[10] 42 CFR §483.15 (e)(1)(ii)
[11] DHCS APL 23-001 Supersedes APL 21-006, "Network Certification Requirements," Attachment A.
[12] DHCS APL 23-004

Program.[13]

F. 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.

G. 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.

1. The criteria for admission are set forth in Title 22 of the California Code of Regulations Sections 51335, 51335.5, 51335.6, and 51334, and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in Title 22 of the California Code of Regulations.[14]
2. The determination of the appropriate level of care are based on definitions set forth in the following sections of Title 22 of the California Code of Regulations:[15]
   a. Skilled Nursing Facility - Section 51121
   b. Subacute Level of Care - Section 51124.5
   c. Pediatric Subacute Care Services - Section 51124, 51124.6
   d. Intermediate Care Services - Section 51118, 51120
   e. Nursing Facility – Section 51120.5

H. IEHP and its IPAs cover a Member stay in a facility with availability regardless of medical necessity if placement in a medically necessary appropriate lower level of care is not available. IEHP must coordinate with its IPAs to continue to attempt to place the Member in a facility with the appropriate level of care, including offering to contract with facilities within and outside of the service area.[16]

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

[13] DHCS APL 21-003 Supersedes APL 16-001, "Medi-Cal Network Provider and Subcontractor Terminations"
[14] DHCS APL17-017
[15] Title 22 California Code of Regulations (CCR) § 51124
[16] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.7 Services for All Members

1. The Member requires continuous availability of skilled nursing services or skilled rehabilitation services daily.
2. Only contracted LTCs are utilized. If none are available, either the Member's IPA or IEHP, based on financial responsibility, shall initiate a letter of agreement (LOA) prior to admission.
3. The Member's eligibility and schedule of benefits are verified prior to authorizing appropriate services and within the first five (5) days of each month for Members remaining in LTC.

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

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

1. Clinical progress notes must be received within two (2) business days of admission and at least weekly until discharge, unless directed otherwise by the IEHP LTC Review Nurse.
2. Timely submission of clinical progress notes is required in order to determine whether continued stay at this level of care remains medically necessary. Therefore, untimely submission of clinical progress notes could result in denial of skilled days.
3. Discharge planning should begin upon admission. IEHP must be informed of any discharge need requiring authorization as soon as need is known and prior to day of discharge (See Attachment, "Service Request Form for Skilled Nursing Facilities" in Section 14).

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

M. UM staff, together with the interdisciplinary team of Providers and staff, guide the Member toward meeting the treatment plan goals that include transfer to a lower level of care when it is medically appropriate.

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

O. 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).

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

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

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

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

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

S. 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

T. IEHP provides continuity of care to new Members residing in out-of-area/out-of-network Skilled Nursing Facility (SNF) through continued access to the LTC facility for up to 12 months 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."

U. IEHP will authorize Accommodation Codes as follows:

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

U. IEHP utilizes a Long-Term Services and Supports (LTSS) Liaison to assist facilities in addressing claims and payment inquiries and assist with care transitions among the LTC Provider community to best support Members' needs[17]. The IEHP LTSS Liaison is:

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

   Jauregui-B@iehp.org

   909-296-3533

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

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

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	☒ DMHC	☐ NCQA
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[17] DHCS APL 23-004

14. UTILIZATION MANAGEMENT

G. Acute Inpatient Admission and Concurrent Review

APPLIES TO:

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

POLICY:

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

B. IEHP ensures the provision of discharge planning when a Member is admitted to a Hospital or Long-Term Acute Care (LTAC) facility and continuation into the post-discharge period. This shall ensure that necessary care, services, and supports are in place in the community for the Member once they are discharged.[2]

PURPOSE:

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

PROCEDURES:

Hospital/Facility Responsibilities

A. Contracted and non-contracted Hospitals and LTAC facilities must notify IEHP upon a Member's planned or unplanned inpatient admission or as soon as the facility deems the need 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. Such notification may be done via fax at (909) 477-8553, phone or electronic health record data exchange. Non-contracted facilities can notify IEHP of admission 24 hours a day by phone at 866-649-6327.

    1. Hospitals must supply IEHP a notification of admission for standard obstetric (OB) deliveries. However, no prior authorization is needed for these services and hospitals should bill post-discharge. Please refer to Section 20, "Claims Processing" for additional

[1] California Health and Safety Code (Health & Saf. Code) § 1367.01
[2] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.3.11, Transitional Care Services

guidance on billing procedures. Length of stay for standard OB deliveries is defined as follows:[3]

a. Two (2)-day stay for vaginal delivery

b. Four (4)-day stay for cesarean delivery

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

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

D. The Hospital or LTAC facility must begin discharge planning upon admission and inform IEHP of any discharge needs that may require authorization as soon as need is known and no later than the day prior to day of discharge (see "Acute Hospital Discharge Needs Request Form" found on the IEHP website[4]).

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

E. Discharge planning must ensure that necessary care, services, and supports are in place in the community for the Member once they are discharged from the Hospital or LTAC, including scheduling an outpatient appointment and/or conducting follow-up with the Member and/or caregiver. Contractor must provide a Discharge Planning document to Members, Member's parents, legal guardians, or authorized representatives, as appropriate. The discharge planning document must include, at minimum:[5]

1. Documentation of pre-admission status, including living arrangements, physical and mental function, substance use disorder (SUD) needs, social support, durable medical equipment (DME), and other services received prior to admission;

2. Documentation of pre-discharge factors, including the Member's medical condition, physical and mental function, financial resources, and social supports at the time of discharge;

3. The hospital, institution or facility to which the Member was admitted;

4. Specific agency or home recommended by the hospital, institution or facility after the Member's discharge based upon Member needs and preferences; specific services needed after discharge, specific description of the type of placement preferred and agreed to by the Member or their representative, specific descriprion of the agency or home

[3] Title 45 Code of Federal Regulations (CFR) §146.130
[4] https://www.iehp.org/en/providers/provider-resources?target=forms
[5] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.3.11, Transitional Care Services

recommended by the facility and agreed to by the Member or their representative, and recommended pre-discharge counseling;

5. Summary of the nature and outcome of the Member or their representative's involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the Hospital, institution or facility to be included in the Member's Medical Record.
6. Information regarding available care, services , and supports that are in the Member's community once the Member is discharged from a hospital, institution or facility, including the scheduled outpatient appointment or follow-up with the Member.

F. The Hospital or LTAC facility must submit all clinical documentation within one (1) business day post-discharge. If clinical documentation is not received timely, IEHP will issue a denial of payment to the facility due to lack of clinical documentation supporting medical necessity.

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

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

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

IPA Responsibilities

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

B. Starting at admission, IPAs must collaborate according to the division of financial responsibility (DOFR) with the hospital and IEHP to ensure that all discharge needs of the Member are met.

IEHP & PCP Responsibilities

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

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

C. Reviews are performed based on nationally recognized clinical criteria and IEHP Utilization Management Subcommittee Approved Authorization Guidelines. Reviews may also include physician communication and ongoing communication with other healthcare professionals

involved in the Member's care, as necessary. Determinations are made within one (1) business day of receiving all clinical documentation and are communicated to the facility within twenty-four (24) hours of the decision.[6] 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.

D. If IEHP denies the continued stay and the attending physician does not agree with the decision, either the attending physician or the Member may initiate an expedited appeal. Following completion of the expedited review process, the admission is either authorized or denied. Care must not be discontinued until the treating Practitioner has been notified and the treating Practitioner has agreed upon a care plan.[7] Please see Section 16, "Grievance and Appeal Resolution System" for more information.

E. For denials of care or service, IEHP notifies the Hospital/Facility verbally within twenty-four (24) hours of the receipt of clinical documentation. If oral notification is given within twenty-four (24) hours of the request, then a written or electronic notification is given no later than three (3) calendar days after the oral notification.

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

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

H. IEHP and its IPAs must ensure that Provider-Preventable Conditions (PPCs) are reported to the California Department of Health Care Services.[8,9,10] See Policy 13D, "Reporting Requirements Related to Provider Preventable Conditions."

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

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14. UTILIZATION MANAGEMENT

H. Hospice Services

APPLIES TO:

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

POLICY:

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

DEFINITION:

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

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

PROCEDURES:

Hospice Care

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

1. Nursing services;
2. Physical, occupational, or speech–language pathology;
3. Medical social services under the direction of the physician;
4. Home health aide and homemaker services;
5. Medical supplies and appliances;
6. Drugs and biologicals;
7. Physician services;

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

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

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

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

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

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

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

E. Hospice care services may be initiated or continued in a home or clinical setting. Hospice care may be provided while the Member resides in a skilled nursing facility (SNF) or intermediate care facility (ICF). Hospice care services are not categorized as long-term care services regardless of the Member's expected or actual length of stay in a nursing facility while also receiving hospice care. IEHP does not require authorization for room and board.[9]

Member Eligibility and Election of Services

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

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

of services related to the terminal condition.[10]

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

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

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

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

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

Initiation of Hospice Care

A. IPAs that receive a request for hospice care must submit the referral request form immediately to IEHP via the secured provider portal. Out of network provider referrals can be sent by fax to (909) 297-2513.

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

C. IEHP Members are to be referred to an IEHP Quality Hospice Network provider unless a special circumstance request has been granted as outlined in item D in this section.

D. In the following scenarios, IEHP considers allowing the Member to remain with the established hospice care Provider until the new election period, or until the end of hospice services:

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

1. New Members receiving hospice at the time of their enrollment with IEHP may not be able to change their hospice care Provider even if requested due to limitations on the number of times there may be a change in the designation of a hospice care Provider during an election period; and/or
2. If it is determined that a change in hospice care Providers would be disruptive to the Member's care or would not be in the Member's best interest.

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

1. The Hospice Provider must determine the medical necessity for general inpatient level of care. The request must be submitted to IEHP with the following:
   a. Certification of Physician orders for general inpatient hospice care; and
   b. Justification for this level of care.
2. IEHP will coordinate and arrange for authorized services with contracted hospice care Providers.
3. Requests for general inpatient level of care must be submitted within 48 hours of change in level of care.

Hospice Care Provider Responsibilities

A. Hospice network providers submit all forms and documentation via the IEHP secure provider portal. Out of network providers submit forms and documents via fax to (909) 297-2513.

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

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

D. Hospice Notice of Election (NOE): When a member elects hospice services, the hospice must complete an election notice with the member and submit a copy of the NOE to IEHP upon admission and no later than 7 business days from admission.

E. Certification of Terminal Illness (CTI): The initial written Certification of Terminal Illness (CTI) must be submitted upon admission and no later than 30 days. For each subsequent recertification period, the hospice care Provider submits the CTI no later than the expiration of the current certification period. The CTI must contain the qualifying clause: "The individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course." CTI recertification periods are as follows:

[18] DHCS APL 13-014

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

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

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

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

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

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

J. When discharging a Member from hospice care due to patient expiration, the hospice care Provider must submit the Discharge Summary to IEHP within five (5) business days of the Member expiring.

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

L. When a Member changes designation of hospice provider, the hospice shall provide transferring Member with a transfer summary including essential information relative to the

patient's diagnosis, pain treatment and management, medications, medical treatments, dietary requirements, known allergies, treatment plan and previous hospice benefit information.

M. The hospice care Provider is required to participate in the Consumer Assessment of Healthcare Providers and Systems CAHPS® Hospice Survey and have publicly available scores each quarter to remain in the network. In addition, Hospice Item Set (HIS) data must be submitted as required by the Centers for Medicare and Medicaid Services (CMS).

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

O. When the Member's death is imminent, the hospice care Provider must conduct daily visits and document daily, unless declined by member/member's representative and supported by documentation of the hospice care provider.

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

Q. Hospice network Providers must participate in and attend IEHP's bi-annual Joint Operations Meetings.

R. Hospice network Providers will be required to complete and submit an annual reassessment survey to IEHP by the date determined by IEHP.

S. Hospice network providers will review and make reasonable efforts to meet any annually published value-based incentive metrics as available via separately published guidelines.

IEHP Responsibilities

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

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

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

C. Ongoing care coordination shall be provided to ensure that services necessary to diagnose, treat, and follow up on conditions not related to the terminal illness continue to be provided

or are initiated as necessary.[19]

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[19] DHCS APL 13-014

14. UTILIZATION MANAGEMENT

I. My Path Palliative Care Program

APPLIES TO:

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

POLICY:

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

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

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

PURPOSE:

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

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

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

DEFINITIONS:

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

B. Palliative Care – The Centers for Medicare and Medicaid Services (CMS) defines palliative care as: "patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice." Many physicians and practitioners note that palliative care is an overall approach to the practice of medicine that is broader than end-of-

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

life care and is for "any age and any stage" of illness.[4] Palliative does not require the Member to have a life expectancy of six (6) months or less and may be provided concurrently with curative care.[5]

PROCEDURES:

A. **Program Overview**[6]

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

[4] CA WIC, §14132.75 (a)(4)
[5] CA WIC § 14132.75 (a)
[6] DHCS APL 18-020

services already received through another Medi-Cal funded benefit program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. **Program Criteria for Identification**

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

C. **Member Identification**

1. Eligible Members will be identified, assessed for program eligibility, and referred to the My Path Program through multiple means.[8]

   a. On a regular basis, IEHP will provide its My Path Palliative Care Provider network with a report that identifies Members with eligible diagnoses and determination of complexity and severity. The My Path Palliative Care Provider network shall reach

[7] DHCS APL 18-020

[8] National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, PHM 1, Element B, Factor 3

out to these Members and perform an in-person clinical assessment for program eligibility.

b. Members admitted to the inpatient setting will be screened for potential eligibility. Identified Members will be authorized consultations with the My Path Palliative Care Provider who will perform an in-person clinical assessment for program eligibility.

c. Requests by Provider network for My Path consultations will be approved. My Path Palliative Care Providers will perform the consultation and complete a clinical assessment for program eligibility.

2. Eligible Members can decline participation in the program.[9]

3. Members must also have the option to opt-out of the program. If identified with a health status change, the Member may be offered the My Path Palliative Care program again, regardless of the previous opt-out status. An example of a change in health status is hospital admission, discharge or a new diagnosis.[10]

D. **Monitoring and Oversight**

1. IEHP monitors Member access to care through access studies, review of grievances, and other methods. Access to palliative services will comply with regulatory timely access standards.

2. IEHP will monitor palliative care enrollment, network, and utilization data according to the following method:

a. Enrollment, access, and utilization metrics will be reported on a regular basis with guidance to improve adverse findings per committee direction.

b. Eligible Members identified through IEHP reports and consultation authorizations will be tracked to ensure access to community-based palliative care is compliant with regulatory standards.

c. Utilization analysis will include monitoring inpatient admissions and emergency room visits prior to program enrollment as compared to during program enrollment.

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

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

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

1) Requirements under the current All Plan Letter;

2) Quality of Care Standards; and

[9] NCQA, 2022 HP Standards and Guidelines, PHM 1, Element B, Factor 3
[10] Ibid.
[11] DHCS APL 18-020

3) Contractual obligations.

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

1) Passing 90-100%

2) Non-Compliant <90%

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

1. All My Path Palliative Care Providers who score 90% or greater pass the audit. However, all Providers with scores less than 100% may be required to submit a CAP to remedy any identified deficiencies.
   a. The My Path Palliative Care Provider must submit a complete and comprehensive CAP response form (See "My Path Palliative Care Program CAP Form" found on the IEHP website[12]) to IEHP that adequately addresses all deficiencies.
   b. A CAP is considered complete only if all deficiencies are present and submitted together.
2. The CAP must be submitted to IEHP within thirty (30) calendar days of written notification by IEHP of the audit results. The CAP must include the following:
   a. The My Path Audit score received;
   b. A list of the deficiencies identified by IEHP;
   c. CAPs must identify the root cause analysis for the deficiency;
   d. CAPs must specifically state how the deficiency is corrected and must include supporting documentation, which may include but not limited to policies and procedures, training agenda, training materials and sign in sheets when applicable;
   e. Completion dates for each of the corrective actions;
   f. Identification of the person responsible for completing the corrective action; and
   g. Follow-up or monitoring plan to ensure that the corrective action plan is successful.
3. Upon receipt of the CAP, IEHP reviews the CAP and either approves or denies the CAP in writing within thirty (30) calendar days of receipt.
4. If the CAP is denied:
   a. IEHP will communicate all remaining deficiencies to the My Path Palliative Care Provider with a written request for a second CAP.
   b. My Path Palliative Care Providers requiring a second CAP may be frozen to new authorizations until a CAP is received and approved.
   c. The My Path Palliative Care Provider is required to resubmit a second CAP within fifteen (15) calendar days to IEHP.

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

5. Upon receipt of the second CAP by IEHP:
   a. If the second CAP is approved, the CAP process is closed. If applicable, the My Path Palliative Care Provider is then re-opened to new authorizations.
   b. If the second CAP is denied, the My Path Palliative Care Provider may be placed in a contract cure process that gives the Provider thirty (30) days to adequately correct the deficiencies.
6. Failure to submit CAPs may result in one of the following activities, depending on the nature of the audit and the seriousness of the deficiency:
   a. Request for cure under contract compliance;
   b. Contract non-renewal; or
   c. Contract termination.

F. **Appeals**

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

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