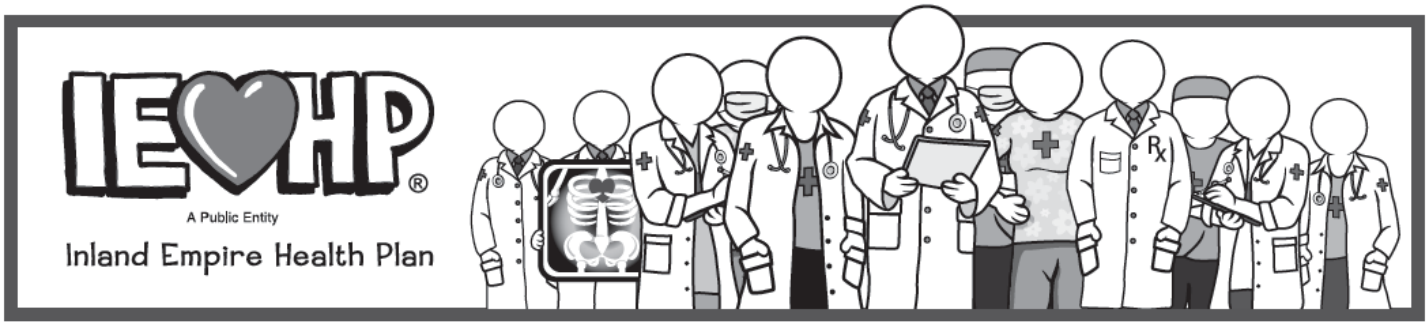

To: Home Health Providers

From: IEHP – Utilization Management

Date: April 17, 2020

Subject: **REMINDER: Home Health Check Off List for Referral Requests**

Inland Empire Health Plan's Utilization Management (UM) department understands the increased workload that all home health agencies are experiencing at this time. The goal of the UM department is to review all home health referrals as expeditiously as possible.

To help us with the review process, please ensure that the **Home Health Check Off List** is attached when submitting Home Health referrals. The **Home Health Check Off List** does not replace clinical notes and should be used as a guideline when determining what notes are required.

When used as directed, the **Home Health Check Off List** will ensure Home Health referrals are submitted with sufficient clinical documentation, to demonstrate medical necessity for initial and continued services.

The **Home Health Check Off List** is attached for your reference and is also available on the IEHP Provider portal at: www.iehp.org > For Providers> Provider Resources > Forms> UM/CM

As a reminder, all communications sent by IEHP can also be found on our Provider portal at: www.iehp.org > For Providers > Plan Updates > Correspondence.

If you have any questions, please do not hesitate to contact the IEHP Provider Relations Team at (909) 890-2054.

Enclosure: Home Health Check Off List

A Public Entity
Inland Empire Health Plan

Home Health Check Off List
Required for all Home Health requests for Continued Service

Home Health Agency Contact Information

Contact Person: _____

Contact Number: _____

CHECK ALL THAT APPLY:

Requested Service	Required Documentation
☐ Nursing	
☐ Medication Management	▪ Clinical notes demonstrating medical necessity.
☐ IV Medication	▪ MD orders. Expected IV therapy end date.
☐ Wound Care	▪ Wound notes. Wound measurements.
☐ Other Skilled Need	▪ Clinical notes demonstrating medical necessity.
☐ Shift Care/Private Duty Nursing	▪ Clinical notes demonstrating medical necessity. ▪ Include hours/day, days/week, total units. ▪ Include detail on referral request form.
☐ Physical Therapy	▪ PT Notes: Prior level of function. Current level of function. Goal level of function.
☐ Occupational Therapy	▪ OT Notes: Prior level of function. Current level of function. Goal level of function.
☐ Speech Therapy	▪ ST Notes: Prior level of function. Current level of function. Goal level of function.
☐ Social Worker	▪ Clinical notes demonstrating medical necessity.
☐ Home Health Aide	▪ Clinical notes demonstrating medical necessity.

**** ALL REQUESTS SHOULD BE SUBMITTED WITH SIGNED MD ORDERS ****

Please return this form along with a **completed referral request and clinical documentation** to the IEHP UM Department at **(909) 890-5751**.

Initial document data: 04/05/2019
Revised: 04/18/2019