14. UTILIZATION MANAGEMENT

A. Review Procedures
   1. Primary Care Physician Referrals

**APPLIES TO:**

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

**POLICY:**

A. IEHP delegates the responsibility for providing general medical care for Members to Primary Care Physicians (PCPs).

B. PCPs are responsible for requesting specialty care, diagnostic tests, and other medically necessary services through their IPA’s referral process.

C. Delegates are responsible for the processing, tracking, and reporting of referrals as specified by IEHP.

**PROCEDURES:**

A. Referrals to Specialists, second opinions, elective Hospital admissions, or any services which require prior authorization are initiated by PCPs or Specialists through their IPA. Prior authorization for proposed services, referrals, or hospitalizations involve the following:
   1. Verification of Member eligibility by the IPA;
   2. Written documentation by the PCP or Specialist of medical necessity for a service, procedure, or referral;
   3. Verification by the IPA that the place of service, referred to Practitioner or Specialist is within the IEHP network; and
   4. Assessment of medical necessity and appropriateness of level of care with determination of approval or denial for the proposed service or referral.

B. PCPs must maintain a Referral Tracking Log for all referrals submitted to IEHP or their IPA for approval in accordance with Policy 14A2, “Review Procedures – Primary Care Physician (PCP) Referrals– PCP Referral Tracking Log” (See Attachment, “Referral Tracking Log” in Section 14). The prior authorization/referral process must meet all standards, including timeliness, as delineated in Policy 25E1, “Utilization Management Delegation and Monitoring.” The Referral Tracking Log is reviewed and monitored during Facility Site Review, Medical Record Review Survey and Interim Audits, or as required in accordance with Policy 7A, “PCP and IPA Medical Record Requirements”.

C. Decisions for routine referrals must be made within five (5) business days of receipt of request. Decisions for urgent/urgent concurrent referral decisions along with electronic/written notification to the Practitioner and Member within seventy-two (72) hours from the receipt of the request. The PCP informs Members that if the referral is
14. UTILIZATION MANAGEMENT

A. Review Procedures

1. Primary Care Physician Referrals

denied or partially approved (modified), they can file an appeal/grievance with IEHP. A written notice of denial that includes the appeal/grievance process must be provided.

D. Referrals to out-of-network specialists, providers or practitioners require documentation of medical necessity, rationale for the requested referral, and prior authorization from IEHP or the IPA. Once the prior authorization has been obtained, the PCP must continue to monitor the Member’s progress to ensure appropriate intervention and assess the anticipated return of the Member to the IEHP network.

E. Members requiring special tests/procedures or referral to a Specialist, if required by IEHP or the IPA, must first obtain prior authorization through IEHP or the IPA.

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 reports information, initials and dates the report once reviewed, and formulates a follow-up care plan for the Member. 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 assessed during periodic chart audits with oversight by IEHP.

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

G. Please refer to Policies 12K1, “Behavioral Health - Behavioral Health Services” and 12K2, “Behavioral Health - Alcohol and Drug Treatment Services” for information on the referral process for behavioral health services.
14. UTILIZATION REVIEW

A. Review Procedures
   2. Primary Care Physician Referral Tracking Log

APPLIES TO:

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

POLICY:

A. All Primary Care Physicians (PCPs) are required to maintain a system for tracking all referrals submitted to their IPA.

PROCEDURES:

A. All PCPs must maintain an authorization log that contains all of the information noted below:
   1. Date referral sent to IPA;
   2. Member name and date of birth;
   3. Acuity of referral;
   4. Reason for referral/diagnosis;
   5. Service or activity requested;
   6. Date authorization received;
   7. Referral decision;
   8. Patient notified;
   9. Date of appointment or service; and
   10. Date consult report received or outreach effort.

B. PCPs may either use the PCP Referral Tracking Log (See Attachment, “PCP Referral Tracking Log” in Section 14) or another system that contains all of the above-required information.

C. PCPs must utilize the referral log to coordinate care for the Member and to obtain assistance from their IPA if specialty appointments are delayed, or consultation notes are not received.

D. Referral logs, or equivalent system, must be available at all times at the PCP site.

E. Copies of referrals and any received consultation and/or service reports must be filed timely in the Member’s medical record.
14. UTILIZATION REVIEW

A. Review Procedures
   2. Primary Care Physician Referral Tracking Log
14. UTILIZATION MANAGEMENT

A. Review Procedures

3. Standing Referral/ Extended Access to Specialty Care

APPLIES TO:

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

POLICY:

A. IEHP and its Delegates are required to establish and implement procedures for Primary Care Physicians (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 for a Member who has a life threatening, degenerative or disabling condition that requires coordination of care by a Specialist.

B. Members with a life-threatening, degenerative or disabling condition or disease must receive a referral to a Specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the Specialist or specialty care center coordinate the Member’s care.

C. Practitioners that are Board-Eligible in appropriate specialties, e.g., Infectious Disease, are able to 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 Practitioners who have demonstrated expertise in treating a condition or disease involving a complicated treatment regimen that requires ongoing monitoring by contacting IEHP at (800) 440-4347 or for TTY (800) 718-4347.

D. PCPs are responsible for coordinating the care of the Member in consultation with the Specialist, IPA and the Member.

PROCEDURES:

A. IEHP and its Delegated IPAs must develop and implement a procedure for standing referrals or extended access to a Specialist at the Member or PCP request. The PCP and/or Member determines, in consultation with the Specialist and/or the Medical Director or designee, if a Member needs continuing care from a Specialist.

B. After consultation with the Specialist as needed and the Medical Director, the PCP must submit his/her request for a standing specialty referral or extended access to their IPA in writing, using the designated form (See Attachment, “Standing Referral/Extended Access Referral to Specialty Care” in Section 14). Appropriate medical records must be attached to the request.

C. Standing referrals are processed according to turnaround timeframes as outlined in Policy 25E1, “Utilization Management Delegation and Monitoring”.
14. UTILIZATION MANAGEMENT

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

D. If IEHP or the IPA determines that the standing referral should be limited in terms of number of visits or timeframe, IEHP or the IPA, in consultation with the PCP and Specialist, must develop a treatment plan specifying the limits.

E. Standing referrals or extended access to specialty care approved without limitations do not require a treatment plan or IEHP approval.

F. Potential conditions necessitating a standing referral and/or treatment plan include but are not limited to the following:
   1. Significant cardiovascular disease;
   2. Asthma requiring specialty management;
   3. Diabetes requiring Endocrinologist management;
   4. Chronic obstructive pulmonary disease;
   5. Chronic wound care;
   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.

G. 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.

H. 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.
14. UTILIZATION MANAGEMENT

A. Review Procedures

3. Standing Referral/ Extended Access to Specialty Care

I. 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.

1. Upon Member request for a standing referral, the PCP shall make a determination within three (3) business days whether to submit a standing referral to IEHP or the IPA. This determination should be made after consulting with the Member’s treating Specialist.

2. Once a decision is made that a standing referral is needed, the PCP must submit a request for standing specialty referral to IEHP or the IPA within four (4) business days, using the designated form (See Attachment, “Standing Referral/Extended Access Referral to Specialty Care” in Section 14). Appropriate medical records must be attached to the request. A determination will be rendered by IEHP or IPA Medical Director (or designee).

J. After approval of the request for standing specialty or extended access to specialty care, with or without a treatment plan, IEHP and the Delegates are required to notify the PCP, Specialist, and Member in writing within regulatory timeframes.

K. IPAs must forward all denials of requests for standing specialty or extended access to specialty care to IEHP within three (3) business days of the denial. IPAs must also inform the PCP, Specialist, and Member of the denial in writing, according to prescribed formats for denials. Please refer to Policy 25E1, “Utilization Management Delegation and Monitoring”.

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

Out of Network

A. IEHP and its Delegated IPAs are not required to refer Members to out-of-network practitioners unless appropriate specialty care is not available within the network.

B. IEHP and its Delegated IPAs must provide and coordinate any out-of-network services adequately and timely when such services are medically necessary and not available within the network.

C. IEHP and its Delegated IPAs must coordinate payment with out-of-network providers and ensure that cost to the Member is not greater than it would be if the services were furnished within the network.

D. IEHP and its Delegated 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 Delegated IPA in conjunction with IEHP’s Chief Medical Officer, as warranted.
14. UTILIZATION MANAGEMENT

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

REFERENCES:

A. Health and Safety Code §1374.16.
B. Title 28 California Code of Regulations §1300.74.16(e) & (f).
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 its Members a 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

B. Primary Care Physicians (PCPs), Specialists, and Members (if the Provider refuses) or their representative, have the right to request a second opinion from their IPA regarding proposed medical or surgical treatments from an appropriately qualified participating healthcare professional acting within their scope of practice who possesses a clinical background, including training and expertise, related to the particular illness, disease condition or conditions associated with the request for a second opinion.3

C. Second opinions are authorized and arranged through the Member’s IPA.

D. The mandated timeframes for decisions of a request for a second opinion and subsequent notification to the Member and Practitioner are available in the Member’s Evidence of Coverage (EOC) and are available to the public, upon request.

PROCEDURES:

A. The Member’s request for a second opinion is processed through their IPA’s prior authorization system. 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.

B. 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.

C. If the referral for a second opinion is approved, the IPA authorizes services for the Member to see a Physician in the appropriate specialty. Agreements with any network or out-of-network practitioner for second opinions must include the requirement that the consultation report for the second opinion be submitted4 within three (3) business days of the visit to the Practitioner.

1 NCQA 2020, HP Standards and Guidelines, MED 1, Element C.
3 Ibid
4 Health & Saf. Code § 1383.15(h)
B. Second Opinions

D. Request may only be denied if the Member insists on an out-of-network practitioner when there is an appropriately qualified Practitioner in-network. If the referral 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.

E. If there isn’t a Physician within the IEHP or the IPA’s network that meets the qualifications for a second opinion, the IPA must authorize a second opinion by a qualified physician outside IEHP’s network and ensure that cost to the Member is not greater than it would be if the services were furnished within the network.

F. IEHP and its IPAs must provide and coordinate any out-of-network services adequately and timely.

G. 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.

H. In cases where the Member faces an imminent and serious threat to his or her 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 Practitioners are completed in a timely fashion not to exceed seventy-two (72) hours after receipt of request, whenever possible.6

I. In situations where the Member believes that the need for a second opinion is urgent, they can request facilitation by IEHP by contacting IEHP Member Services. IEHP reviews such requests, and if determined to be urgent, facilitates the process by working directly with the PCP and the IPA. If the request is determined by IEHP to be not urgent, the Member is referred back to his/her PCP and IPA to continue the process.7

J. IEHP and its IPAs must utilize a Second Opinion Tracking Log (See Attachment, “Second Opinion Tracking Log” in Section 25) to track the status of second opinion requests and to ensure that the second opinion Provider submits the consultation report within three (3) working days of the visit. The log must include all authorized and denied second opinions and must be submitted on a monthly basis through IEHP’s Secure File Transfer Protocol (SFTP) server, by the 15th of the following month. See Policy 25E2, “Utilization Management Reporting Requirements” for more information.

K. Reasons for providing or authorizing a second opinion include, but are not limited to, the following:8

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

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5 Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 1, Members Rights and Responsibilities.
6 DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization.
7 Health & Saf. Code § 1383.15(c)
8 Health & Saf. Code § 1383.15(a)
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 PCP/Specialist 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 physician concerning serious concerns about the diagnosis or plan of care.

L. If the Member is requesting a second opinion about care received from his or her PCP, the second opinion must be provided by an appropriately qualified Physician of the Member’s choice within IEHP’s or the IPA’s network.9

M. If the Member is requesting a second opinion about care received from a Specialist, the second opinion must be provided by any Physician with the same or equivalent specialty within the IPA’s network. If not authorized, additional medical opinions obtained from a physician not within IEHP or the IPA’s network is the responsibility of the Member.10

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

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

P. The second opinion Practitioner is responsible for submitting consultation reports to the Member, requesting Practitioner and PCP within three (3) working days of the visit. If the second opinion is deemed urgent, the submission of the consultation report must be within twenty-four (24) hours of the visit.11

Q. 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 BH Department through the secure IEHP Provider portal within three (3) business days of the 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.

9 Health & Saf. Code § 1383.15(a)
10 Health & Saf. Code § 1383.15(f)
11 Health & Saf. Code § 1383.15(h)
14. UTILIZATION MANAGEMENT

B. Second Opinions

R. The PCP is responsible for documenting second opinions and monitoring receipt of consultation reports on the PCP Referral Tracking Log (See Attachment, “Referral Tracking Log” in Section 14).

S. Mandated timeframes for decision including approval, denial or partial approval (modification) of a non-urgent, urgent or concurrent request for a second opinion and subsequent notification to the Member and Practitioner must follow the timeframes outlined in Policy 25E1, “Utilization Management Delegation and Monitoring.”

T. 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. UTILIZATION MANAGEMENT

C. Emergency Services

APPLIES TO:

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

POLICY:

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

B. IPAs are responsible for payment of professional services rendered to Members at the ED per their contract with IEHP and this policy. IEHP is responsible for the facility and technical services rendered to Members in the ED.

C. Per regulatory requirements, IEHP uses the following definitions of an emergency medical and psychiatric condition:

1. Emergency medical condition means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
   a. 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;
   b. Serious impairment to bodily function; or
   c. Serious dysfunction of any bodily organ or part.

2. Emergency psychiatric condition means a behavioral health crisis which is manifested by acute psychiatric symptoms such that a prudent layperson who possesses an average knowledge of behavioral health could reasonably expect the absence of immediate intervention to result in:
   a. Placing an individual at risk for injuring themselves (Danger to Self);
   b. Placing an individual at risk for injuring others (Danger to Others); or
   c. Serious impairment in an individual’s ability to care for themselves or others (Gravely Disabled).

D. Medical and Behavioral Health Providers 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.

E. The financial responsibility associated with the diagnosis and/or treatment of a Member’s visit to an ED is as follows:
14. UTILIZATION MANAGEMENT

C. Emergency Services

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
   d. Facility components as per the IPA’s contractual agreement with IEHP.

2. IEHP is financially responsible for:
   a. All facility and technical fees; and
   b. The facility and technical components of MSE.

F. 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.

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

H. IPAs with contractual arrangements with EDs differing from the above policies and procedures regarding payment or services are subject to the above noted division of financial responsibility guidelines in the event of disputed claims appealed to IEHP.

I. 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.

J. IEHP and its Delegated IPAs shall make every effort to respond to requests for necessary post-stabilization medical care within thirty (30) minutes of receipt. In the event IEHP or its Delegated IPA does not respond within the timeframe, the services are considered approved.

PROCEDURES:

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

B. 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’.

REFERENCES:


B. Health & Safety Code §§ 1371.4(a) through (d).
14. UTILIZATION MANAGEMENT

C. Emergency Services

C. DHCS Final Rule Contract Amendment January 2018, Exhibit A, Attachments 5 (Utilization Management), 7 (Provider Relations), 8 (Provider Compensation Arrangements), 9 (Access and Availability), and 10 (Scope of Services).


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14. UTILIZATION MANAGEMENT

D. Pre-Service Referral Authorization Process

APPLIES TO:

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

POLICY:

A. Primary Care Physicians (PCPs) are responsible for providing general medical care for Members and requesting specialty care, diagnostic tests, and other medically necessary services either through the IPA’s or IEHP’s referral authorization process.

B. The PCP must review any referral from an affiliated mid-level Practitioner, i.e., Nurse Practitioner (NP) or Physician Assistant (PA), prior to the submission of the referral. If there are questions about the need for treatment or referral, the PCP must see the Member.

C. IEHP and its Delegated IPAs must have a process in place to allow a Specialist to directly request authorization from IEHP or the Delegated IPA for additional specialty consultation, diagnostic, or therapeutic services.

D. IEHP and its Delegated IPAs are responsible for conducting a referral and pre-service authorization process in compliance with State and Federal requirements, including requirements for parity in mental health and substance use disorder benefits.1

E. IEHP and its Delegated IPAs must ensure that decisions to deny or partially approve (modify) (authorize an amount, duration, or scope that is less than requested) are made by a qualified health care professional with appropriate clinical expertise in the condition and disease.

F. IEHP and its Delegated IPAs must inform non-contracted providers of their referral and prior authorization process at the time of referral. Information must include, at a minimum:
   1. How to submit referrals;
   2. Turnaround timeframes for determinations; and
   3. Services that do not require prior authorization.

G. IEHP and its Delegated IPAs should evaluate PCP and Specialist referral patterns for over and underutilization.

PROCEDURES:

A. The Nurse Practitioner or the Physician Assistant can sign and date the referral form but must document on the form the name of the PCP or Specialist.

B. 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. Referrals that are not prioritized are handled as “routine.” Referrals that

1 Title 42, Code of Federal Regulations, Section 438.910(d) and California Health and Safety Code Section 1367.01
D. Pre-Service Referral Authorization Process

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;

2. The diagnosis (ICD) and procedure (CPT) codes;
3. Pertinent clinical information supporting the request; and
4. Signature of referring physician and date. This may consist of handwritten signature, handwritten initials, unique electronic identifier, or electronic signatures that must be able to demonstrate appropriate controls to ensure that only the individual indicated may enter a signature.

C. Upon receipt of the referral, IEHP and its Delegated IPAs are responsible for verification of Member eligibility and plan benefits.

D. IEHP and its Delegated IPAs 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 (See Attachment, “Specialty Office Service Auth Sets Grid” in Section 14).

E. Prior authorization for medically necessary procedures or other services that can be performed in the office, beyond the initial consultation and up to two (2) follow up visits, should be authorized as a set or unit. For example, when approving an ENT consultation for hearing loss, an audiogram should be approved (See Attachment, “Specialty Office Service Auth Sets Grid” in Section 14).

1. Exceptions - Prior Authorization is not required and Member may self-refer for the following services. All other services require prior authorization:
   a. Family Planning;
   b. Abortion Services;
   c. Sexually transmitted infection (STI) treatment;
   d. Sensitive and Confidential Services;
   e. HIV Testing and counseling at the Local Health Department;
   f. Immunizations at the Local Health Department;
   g. Routine OB/GYN Services, (including prenatal care by Family Care Practitioner (credentialed for obstetrics) within IEHP network;
   h. Out of area renal dialysis;
   i. Urgent Care;
   j. Preventative services;
   k. Urgent support for home and community service-based recipients; and
14. UTILIZATION MANAGEMENT

D. Pre-Service Referral Authorization Process

1. Other services as specified by the Centers for Medicare and Medicaid Services (CMS).

F. 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. Home oxygen and oxygen supplies must have oxygen saturation levels on room air annually;
   2. CPAP/BiPAP supplies;
   3. Ostomy supplies;
   4. Incontinent supplies;
   5. Insulin pump supplies;
   6. Enteral/Parenteral feeding pump supplies;
   7. TENS unit supplies; and
   8. Suction canisters.

G. 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. 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 assess the anticipated return of the Member into the network.

H. Decisions for referrals must be made in a timely fashion – not to exceed regulatory turnaround timeframes for determination and notification of Members and Practitioners. See Policy 25E1, “Utilization Management - Delegation and Monitoring”. All timeframes must meet regulatory requirements.  

I. IEHP and its Delegated IPAs should monitor the PCP’s rate of referrals to Specialists to:
   1. Monitor for potential over or under utilization of Specialists; and
   2. Identify referral requests that are within the scope of practice of the PCP.

J. When IEHP or the Delegated IPA identifies a potential problem with the PCP’s referrals to Specialists, interventions need to be implemented that address the specific circumstances that were identified during the monitoring process. Interventions, such as written correspondence to the PCP that addresses the identified concern with supporting policy or contract attached, or the Medical Director contacting the PCP to discuss the concern, should be attempted to help educate the PCP.

K. There must be documented evidence of the corrective action taken by IEHP or the Delegated IPA, including the PCP’s response to the intervention. The PCP’s referral pattern must be

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2 Title 42 of the Code of Federal Regulations Sections 438.210, 422.568, 422.570, and 422.572
14. UTILIZATION MANAGEMENT

D. Pre-Service Referral Authorization Process

re-evaluated after a sufficient amount of time (at least sixty (60) days) has elapsed to monitor effectiveness.

L. Specialists are required to forward consultation notes to the PCP within two (2) weeks of the visit.

M. In the event a Specialist or sole proprietor is terminated, IEHP or Delegated IPA coordinates the redirection of assigned Members as needed.

REFERENCES:

A. Title 42, Code of Federal Regulations §§ 422.568, 422.570, 422.572, 438.210, and 438.910(d).

B. Health and Safety Code § 1367.01.


D. DMHC Technical Assistance Guidelines, Utilization Management.

E. NCQA, 2019 HP Standards and Guidelines, Utilization Management (UM) 4.
APPLIES TO:

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

POLICY:

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

B. IEHP requires a thorough functional/safety evaluation performed by an independent third party to determine the medical necessity of custom wheelchair/power wheelchair requests. These evaluations must be performed by a Physiatrist or Qualified Rehabilitation Professional that has no financial relationship with the vendor, as authorized by the Delegated IPA. If the Delegated IPA does not submit a thorough functional/safety evaluation to support the medical necessity of the custom wheelchair/power wheelchair request, then IEHP will have the option to obtain this at its discretion and will deduct from the Delegated IPA’s capitation payment.

C. Custom wheelchair/power wheelchair requests should be reviewed by the Delegated IPA’s Medical Director.

D. Requests that meet the criteria are forwarded to IEHP for wheelchair purchase.

E. IEHP will arrange for a seating evaluation, either facility-based or in-home, for Members who need custom wheelchairs, power wheelchairs, non-routine wheelchair therapeutic seat cushions, and/or wheelchair positioning systems.

F. IEHP is responsible for repairs, maintenance, and rental of custom wheelchairs for qualified individuals.

PROCEDURES:

A. Prior to the submission of a request to IEHP for the purchase of a custom wheelchair/power wheelchair, the Member must undergo 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 Delegated IPA.

B. Once the functional/safety evaluation has been completed and the Delegated IPA determines the request for the purchase of a custom wheelchair/power wheelchair (based on the specialist evaluation) meets criteria, the Delegated IPA will forward the documentation to IEHP for determination.

C. The Delegated IPA needs to submit the referral via fax with all supporting documentation to IEHP’s Utilization Management (UM) department no later than one (1) business day from the Delegated IPA’s decision.
14. UTILIZATION MANAGEMENT

E. Wheelchair Purchase Referral Procedure

1. The referral form must be faxed to IEHP’s UM department at (909) 890-5751 for review and coordination of services (See Attachment, “Health Plan Referral Form for Out-of-Network and Special Services” in Section 14).

2. Referral requests to IEHP for the purchase of a custom wheelchair/power wheelchair must be accompanied at a minimum with the following:
   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. IEHP’s UM department will review the referral and the supporting documentation to make a determination within the timeframes outlined in the UM Timeliness Standards from the receipt of the referral from the Delegate. Please refer to Policy 25E1, “Utilization Management Delegation and Monitoring” for more information on timeliness standards.

E. Notification will be provided to the Delegate, requesting Provider, and PCP regarding the determination.

F. IEHP will arrange for the Member to be assessed for a seating evaluation, either facility-based or in-home, to determine equipment needs.

G. Unless otherwise informed, the equipment will be delivered to the Member’s home.

H. The Seating Evaluator will contact the Member and schedule a post-delivery assessment that will include the Durable Medical Equipment (DME) vendor, as needed.

I. IEHP is responsible for all repairs and maintenance of purchased custom wheelchairs/power wheelchair. If a Delegated IPA receives a request for such services, the referral must be faxed to the IEHP UM department at (909) 890-5751 within one (1) business day of receipt of the request.

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14. UTILIZATION MANAGEMENT

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

APPLIES TO:

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

POLICY:

A. Long Term Care (LTC) facilities include skilled nursing, adult subacute, pediatric sub-acute, and other intermediate care units.

B. Members can be admitted to LTC facilities from acute inpatient settings, transition from skilled level, or as direct admits from the community.

C. IEHP and/or IPAs are financially responsible for Medi-Cal Members requiring LTC facility admission. IPA and IEHP financial responsibility for Medi-Cal Members under age 21 or residing in Intermediate Care Facilities for Developmentally Disabled (ICF-DD) continues until the date the Member is disenrolled from IEHP to Medi-Cal fee-for-service (FFS).\(^1\)

D. IPAs are responsible for notifying IEHP of Members who require admission to LTC facilities as direct admits from the community and if the admission to LTC facility is after an acute inpatient admission.

E. IPAs are responsible for coordinating with IEHP the provision of all necessary care coordination for Members in LTC facilities.

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 ensure all nursing facilities and subacute facilities comply with all regulatory guidelines.

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

PROCEDURES:

A. IEHP or the IPAs can admit and are responsible for determining the appropriate level of care for LTC facility placement of Members that transitioned from an acute setting or transitioning from skilled level with assistance from the Member’s IPA Case Management (CM) department, as needed.\(^2\)

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\(^1\) Department of Health Care Services (DHCS) All Plan Letter (APL)17-017 Supersedes APL 03-003, “Long Term Care Coordination and Disenrollment”.

\(^2\) Ibid
14. UTILIZATION MANAGEMENT

F. Long-Term Care (LTC)

   1. Custodial Level

B. Criteria for admission of Medi-Cal Members to various levels of LTC facilities are described in the following sections of Title 22 of the California Code of Regulations:\(^3\)

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

C. For direct admits from the community, the treating Primary Care Physician (PCP) or Specialist must submit a referral to the Member’s assigned IPA requesting admission. IPAs are responsible for forwarding all requests for custodial level upon receipt to IEHP’s Utilization Management Department via fax at (909) 890-5751. IEHP or IPA CM is responsible to assist with coordination of all aspects of the admission, including:

1. Determining the appropriate contracted facility for the Member.
2. Arranging any necessary transport 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.

D. 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-contracked facilities are provided with authorization details verbally.

E. Concurrent review is performed until discharge. Concurrent review can be performed either on-site by chart review or telephonically. Facilities must submit an initial review for custodial level and then at least quarterly, unless directed otherwise by IEHP’s Long-Term Care Review Nurse (see Attachments, “Long-Term Care (LTC) Initial Review Form” and “Long-Term Care (LTC) Follow-Up Review Form” in Section 14).

F. IEHP or IPAs (IPA CM and PCP) 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.

G. IEHP must establish a length of stay estimate for the Member as soon as possible after admission.

H. IEHP is responsible for periodic evaluations to ascertain readiness for transition to a lower level of care such as assisted living, board and care facility, home with CBAS (Community-
14. UTILIZATION MANAGEMENT

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

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.

I. Financial responsibility for Members under age 21 and residing in ICF-DD facilities continues until the Member is disenrolled from IEHP to Medi-Cal FFS. IEHP will ensure that the Member is admitted to a contracted facility.

J. For Medi-Cal Members, IEHP and the Member’s assigned IPA CM 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 IPA facilitates the application for the waiver for the NF Waiver Program as outlined in Policy 12P, “Home and Community-Based Alternatives Waiver Program”. IPAs are financially responsible until the Member is accepted into the NF Waiver Program. If the Member is not accepted into the NF Waiver Program, the IPA and PCP remain responsible for all necessary care and CM until disenrolled to FFS (if long-term care continues).

K. Authorization will be given for bed hold as follows:
   1. The bed hold will be authorized for up to seven (7) calendar days.
   2. A separate authorization will be issued for a seven (7) day bed hold.
   3. If the Member does not return to the LTC facility that requested the hold in seven (7) days, the bed hold will expire.
   4. The LTC facility must accept the Member back, if requested, in order to receive payment for the bed hold.

L. 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. If the Member agrees to the PCP change and/or IPA reassignment, the Member remains in long term care at a custodial level and the IEHP Inpatient Coordinator will complete the request in IEHP’s system.

M. If the Member does not agree to the above changes, they will remain with their current PCP and/or IPA and the IPA will be notified.

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

O. Prior to ninety (90) calendar days in LTC facility, the IEHP Inpatient Coordinator will request a copy of the completed MC171 form (if not already received) with the date it was submitted to the local agency (See Attachment, “MC171 Form and Instruction 05-07” in Section 14).

P. Authorization will be given for Leave of Absence (LOA).
   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.
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.

Q. When new Members residing in an out-of-area/out-of-network Skilled Nursing Facility (SNF) enroll into the health plan and proof of relationship has been established as outlined in Policy 12A2, “Care Management Requirements - Continuity of Care,” IEHP and the IPA shall offer the Member the opportunity to return to the out-of-area/out-of-network SNF after a medically necessary absence, such as a hospital admission. This does not apply to Members discharged from the SNF to the community or lower level of care.

R. Accommodation Codes will be authorized as follows:

1. Accommodation codes do not apply to custodial level of care, unless otherwise indicated by IEHP’s Medical Director for a limited period of time.
2. 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.
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 is responsible for performing all aspects of non-delegated utilization management and care management responsibilities related to Long Term Care (LTC) skilled level placement. IEHP will follow active Members while in an LTC facility.

B. IEHP will only disenroll Members in these scenarios:¹
   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; and/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.

B. To ensure all nursing facilities and subacute facilities comply with all regulatory guidelines, including care coordination which will be facilitated by IEHP.

PROCEDURES:

A. Appropriate LTC skilled level placement involves the following factors:
   1. The Member requires skilled nursing services or skilled rehabilitation services on a daily basis.
   2. Only contracted LTCs are utilized unless none are available, then a letter of agreement (LOA) is requested.
   3. The Member’s eligibility and schedule of benefits are verified prior to authorizing appropriate services. Within the first five (5) days of each month, eligibility is re-evaluated for Members remaining in LTC from the prior month.

B. Primary Care Physicians (PCPs) must evaluate a Member’s need for LTC skilled level

¹ Department of Health Care Services (DHCS) All Plan Letter (APL) 17-017 Supersedes APL 03-003, “Long Term Care Coordination and Disenrollment”.
14. UTILIZATION MANAGEMENT

   F. Long Term Care
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placement. A referral request must be submitted to the Member’s IPA with sufficient medical information from the Member’s PCP for review and recommendation when transitioning from a community or usual setting.

1. For non-delegated UM performed by IEHP, 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 generated.

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

D. All the clinical reviews, discharge date, and discharge needs must be received from the facility in order for the entire stay to be authorized.

E. 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.

F. Concurrent review is performed at least weekly unless directed otherwise by the Long-Term Care Review Nurse until discharge. Concurrent review may be performed either on-site by chart review or telephonically.

G. Reviews should include physician communication and ongoing communication with other healthcare professionals involved in the Member’s care as necessary. Authorization decisions must be made within forty-eight (48) hours of receipt of request.

H. 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;
   7. Expected outcome of the Member’s health status with LTC skilled level placement is obtained through weekly reviews from the facility, unless directed otherwise by IEHP or IPA’s Case Management, for 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 Forms” in Section 14); and
8. Evaluation of alternative care to determine if the Member would be sufficient 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. Adult day care (based upon the Member’s benefit; see Policy 12H1, “Community Based Adult Services (CBAS)” or child day care;
   e. Family education and training; and
   f. Community networks and resources.

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

J. The treatment plan is implemented, evaluated, and revised by the 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 also are involved in the treatment plan implementation process to the extent necessary.

K. The UM/CM 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.

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

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

N. The IPA’s financial responsibility for professional services continues for the month of enrollment into the plan/IPA and admission and month following. Then the responsibility is transferred to the health plan if agreed upon by the Member.

O. The Medical Director or physician designee reviews all medical necessity denials. All denial decisions are made in writing to the PCP, attending physician, facility, and Member. The initial notification is made to the Provider within twenty-four (24) hours through electronic communication (e.g., phone or fax).

P. All stays greater than the month of admission and the month after becomes the responsibility of IEHP-Direct. IPAs are required to transfer the responsibility to IEHP’s Long Term Care (LTC) team if agreed upon by the Member.

Q. IEHP will notify the Member thirty (30) days in advance of any pending PCP and/or IPA re-
14. UTILIZATION MANAGEMENT

F. Long Term Care
   2. Skilled Level

assignment. If Member does not agree to the above changes, they will remain with their current PCP and/or IPA. The IPA will be notified.

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

S. Authorization will be given for bed hold as follows:
   1. The bed hold will be authorized for up to seven (7) calendar days.
   2. A separate authorization will be issued for a seven (7) calendar day bed hold.
   3. If the Member does not return to the LTC facility who requested the hold in seven (7) calendar days, the bed hold will expire.
   4. The LTC facility must accept the Member back, if requested, in order to receive payment for the bed hold.

T. When new Members residing in an out-of-area/out-of-network Skilled Nursing Facility (SNF) enroll into the health plan and proof of relationship has been established as outlined in Policy 12A2, “Care Management Requirements - Continuity of Care,” IEHP and the

U. IPA shall offer the Member the opportunity to return to the out-of-area/out-of-network SNF after a medical necessary absence, such as a Hospital admission. This does not apply to Members discharged from the SNF to the community or lower level of care.

V. Accommodation Codes will be authorized as follows:
   1. Accommodation codes will 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.
14. UTILIZATION MANAGEMENT

G. Acute Admission and Concurrent Review

APPLIES TO:

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

POLICY:

A. Delegated IPAs are responsible to perform inpatient utilization management activities as outlined in their contract.

B. For those Delegated IPAs not delegated to perform inpatient utilization management activities, IEHP is responsible for inpatient concurrent review. The Delegated IPA is responsible for notifying IEHP utilization management (UM) staff of any facility admissions.

C. Contracted and non-contracted facilities are required to notify IEHP or the Member’s Delegated IPA via fax, phone or Electronic Data Interchange (EDI) submission of a Member’s inpatient admission as soon as the facilities deem the Member’s need for inpatient admission.

D. IEHP reviews all clinical documents received and responds within thirty (30) minutes of receipt of clinical documentation. If supporting documentation is received timely and IEHP fails to respond within these timeframes, IEHP will approve the first day of admission for post-stabilization. All subsequent days are subject to review for medical necessity.

E. IEHP requires contracted and non-contracted facilities to submit clinical documentation daily to validate inpatient admission and subsequent stays. 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.

PURPOSE:

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

DEFINITION:

A. Non-Contracted facilities – Facilities that do not have contracted agreements with IEHP.

PROCEDURES:

A. IEHP or its Delegated IPA is notified of all inpatient admissions by the Hospital or long-term acute care (LTAC) facility’s Case Management or Admitting Department of all inpatient admissions, including those planned and unplanned transitions. Admission review is performed within one (1) business day of knowledge of admission.

   1. IEHP and its Delegated IPA’s Inpatient UM department maintains a daily census in their medical management system to identify Members that have transitioned from one setting to another setting.

B. Contracted and non-contracted facilities must notify IEHP upon the Member’s admission to obtain authorization for inpatient stays. All clinical documentation must demonstrate the
G. Acute Admission and Concurrent Review

medical necessity of inpatient admission, based on nationally recognized clinical criteria and submitted to IEHP within twenty-four (24) hours of the Member’s admission. If clinical documents are not received timely, the inpatient admission will be at risk for timely review and may potentially be denied.

C. All continued stays will be authorized concurrently as clinical reviews are received. Contracted facilities can view their authorizations on the secure IEHP Provider portal, while non-contracted facilities will be verbally notified of their authorizations.

1. Final authorization will be given once a discharge date and all discharge needs have been received from the facility, with the exception of when a tracking number may be necessary prior to the admission or transfer for services such as transfer to higher, LTAC, skilled nursing facility (SNF), or acute rehabilitation (AR).

D. Concurrent review is performed 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. Please refer to Policies 14I, “Long Term Care (LTC) – Custodial Level” and 14J, “Long Term Care (LTC) – Skilled Level” for review schedules specific to these levels of care.

E. Reviews should include Physician communication and ongoing communication with other healthcare professionals involved in the Member’s care, as necessary. Authorization decisions must be made within twenty-four (24) business hours of receipt of request.

F. IEHP must receive all clinical documentation within three (3) business days from discharge date. 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. All claims for Hospital days subsequent to the discharge will be reviewed retrospectively. Please see Policy 25E1, “Utilization Management Delegation and Monitoring” for more information.

H. Nationally recognized clinical criteria and IEHP Subcommittee Approved Authorization Guidelines are utilized for justifying medically necessary services at the appropriate level of care (e.g. acute, sub-acute, skilled nursing, and home/community) and length of stay must be applied and documented in a consistent manner. The application of criteria takes into consideration individual factors such as age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment. Additionally, application of criteria 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 care plan.

I. Member eligibility and benefits are verified to ensure appropriate authorization and management of services.

J. Chronic, complex, high risk, high cost, re-admissions or catastrophic cases are referred for potential care management, transition of care (TOC) and/or disease management interventions. Cases are reviewed by the Medical Director or designee who may refer to the
14. UTILIZATION MANAGEMENT

G. Acute Admission and Concurrent Review

UM Subcommittee as deemed necessary.

K. Delegated IPAs that have accountability for inpatient utilization management must notify IEHP of Members with an inpatient stay on day twenty (20) and weekly by completing and faxing the Acute Inpatient Data Sheet along with the face sheet to (909) 477-8553 (See Attachment, “Acute Inpatient Data Sheet” in Section 14). Subsequent reviews must be sent to IEHP weekly until the Member is discharged.

L. Board-certified physicians from appropriate specialty areas assist with determinations of medical appropriateness, as needed.

M. IEHP or its Delegated IPA UM or care management (CM) staff, as appropriate, is assigned to perform Hospital concurrent review and must document findings in the medical management system. If IEHP or the Delegated IPA Medical Director or physician designee, denies the continued stay and the attending physician does not agree with the decision, either the attending physician or 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. Please see Section 16, “Grievance and Appeal Resolution System” for more information.

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

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

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

P. IEHP and its Delegated IPAs’ UM/CM Staff are responsible for identifying and referring any potential quality incidents (PQI) occurring in an inpatient or outpatient setting to IEHP’s Quality Management (QM) department. Indicators used for identification of PQI include the following:

1. Unexpected death (maternal/perioperative/neonatal);
14. UTILIZATION MANAGEMENT

G. Acute Admission and Concurrent Review

2. Unplanned return to the operating room;
3. Anesthesia event (neurological impairment);
4. Extended length of stay due to iatrogenic complications;
5. Retained foreign object;
6. Decubitus development;
7. Nosocomial infection;
8. Readmissions within thirty (30) days of discharge (same diagnosis);
9. Serious Reportable Adverse Events (SRAEs), such as surgery on wrong patient, surgery on wrong body part, etc.; and
10. Provider Preventable Conditions (PPC) and/or Health Care-Acquired Conditions (HCAC).

Q. Focused reviews are conducted for known problem diagnoses, procedures, or Practitioners requiring guidance in managing the utilization of services.

REFERENCES:

B. Title 22, California Code of Regulations §1300.71.4.
**14. UTILIZATION MANAGEMENT**

**H. Hospice Services**

**APPLIES TO:**

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

**POLICY:**

A. Delegated IPAs are accountable for authorizing, managing, and reporting hospice referrals to IEHP.

B. For non-delegated utilization management (UM) activities, IEHP UM and Care Management (CM) staff are responsible for assisting in the management of the Member’s care in the home environment.

C. Hospice services include the provision of palliative care and support services that focus on the Member and family’s physical and psychosocial needs.

D. Prior authorization is not required for hospice services except for inpatient admissions.

E. The only requirement for initiation of outpatient hospice care services is a Physician’s certification that a Member has a terminal illness and a Member’s “election” of such services.

F. Home health and infusion services that are not a part of hospice services require prior authorization.

**DEFINITION:**

A. 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.

**PROCEDURES:**

A. IEHP and Delegated IPAs must implement hospice services (per the Member’s benefit) to achieve the following objectives:

1. Meet the Member’s healthcare needs at home by utilizing contracted Providers and Practitioners who provide hospice services;

2. Assist in the interdisciplinary team management and provision of the Member’s care in the most appropriate setting;

3. Provide services which maximize the Member’s potential to achieve an optimal state of health, ability to function, and comfort in the home environment; and

4. Promote cost-effective healthcare services by reducing the need for hospitalization or facility placement.

B. A designated Primary Care Physician (PCP) or Specialist, if necessary, must have substantial involvement in the implementation of the home health, infusion, and hospice care
C. UM/CM staff must be qualified and appropriately licensed health professionals who are responsible for evaluating a Member’s illness, injury, degree of disability, and medical needs. UM/CM staff evaluate this information for appropriate and timely referral to hospice services and verify a Member’s eligibility and schedule of benefits.

1. The referring PCP or Specialist must determine the medical necessity for hospice services. Only general inpatient hospice care is subject to prior authorization. Documents to be submitted for authorization must include:
   a. Certification of physician orders for general inpatient hospice care; and
   b. Justification for this level of care.

2. Authorized services are coordinated with contracted vendors.

3. Hospice agency will notify IEHP upon enrollment of the Member in hospice care via fax at (909) 297-2513.

4. Hospice agency will submit Certification of Terminal Illness (CTI) upon admission and upon each CTI renewal via fax at (909) 297-2513. 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."

5. Extensions of service requests are authorized either through the Delegated IPA or IEHP.

6. The requested services must be assessed for potential care management and referred as appropriate.

7. All interactions and care must be documented.

D. IEHP staff responsibilities include the following activities:

1. Verify the Member’s eligibility and benefits and only authorize medically appropriate services;

2. Utilize approved guidelines to determine the appropriateness of the referral to home health, infusion, hospice services, or palliative care services;

3. Assess informal resources that may be available (e.g., family, neighbors, etc.) and, when necessary, consult with the county social services agencies or public authorities about available resources; and

4. Coordinate the referral with the PCP and obtain a signed physician’s order indicating the type and length of service required.

E. Services are authorized according to policy and procedure with appropriate notification to the PCP, vendor, and Member. Authorizations are evaluated at a minimum of every thirty (30) days for any continued or extended request for services.

F. Arrangements are made for contracted Providers to carry out the treatment plan that involves
14. UTILIZATION MANAGEMENT

H. Hospice Services

skilled nursing, therapeutic services, and support services as appropriate.

G. UM/CM staff is involved in the management of the Member’s treatment plan and communicates progress and actions to the Delegated IPA or PCP. Staff monitors the Member’s discharge from service and follow-up care, as necessary.

H. All actions regarding the management of hospice services must be documented. Documentation includes treatment, the Member’s response to treatment, activities of daily living (ADL) issues, appointments, and any social concerns.

Hospice

A. Hospice care services include, but are not limited to the following:
   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;
   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. Respite care provided on an intermittent, non-routine, and occasional basis for up to five (5) consecutive days at a time;
   11. Short term inpatient care for pain control or chronic 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. 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.

C. Hospice care services are covered services and 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.

D. A Member (or authorized representative) must elect hospice care to receive it.
   1. The election period shall consist of two (2) periods of ninety (90) days each; and
14. UTILIZATION MANAGEMENT

H. Hospice Services

2. An unlimited number of subsequent periods of sixty (60) days each during the Member’s lifetime.

E. (Medi-Cal only) (Cal. Code of Regulations, tit.22, § 51349) – Elections may be made for up to two (2) periods of ninety (90) days each, one (1) subsequent period of thirty (30) days, and one (1) one hundred eighty (180) day extension of the thirty (30) day period.

F. (Medi-Cal SPD Members under 21) (Social Security Act, Section 1905(o)(1)) – A voluntary election of hospice care for Members under 21 shall not constitute a waiver of any rights of that Member to be provided with, or to have payment made for covered services that are related to the treatment of that Member’s condition for which a diagnosis of terminal illness has been made.

G. If the Member elects an out-of-network (OON) hospice, the Delegated IPA or IEHP has the option of immediately initiating a contract (one time or ongoing) with the Hospice Provider or referring the Member to a network Hospice Provider.

1. In the following scenarios, IEHP or the Delegated IPA should consider a one-time or ongoing contract with the established Hospice Provider until the new election period, or until the end of Hospice services:
   a. New Members receiving hospice at the time of their enrollment with IEHP may not be able to change their Hospice Provider even if requested due to limitations on the number of times there may be a change in the designation of a Hospice Provider during an election period.
   b. If it is determined that a change in Hospice Providers would be disruptive to the Member’s care or would not be in the Member’s best interest.

REFERENCES:

A. Title 22, California Code of Regulations §51349.
B. Social Security Act § 1905(o)(1).
C. Department of Health Care Services (DHCS) All Plan Letter (APL) 13-014 Supersedes APL 07-014, “Hospice Services and Medi-Cal Managed Care”.

<table>
<thead>
<tr>
<th>INLAND EMPIRE HEALTH PLAN</th>
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<tbody>
<tr>
<td><strong>Chief Approval:</strong> Signature on file</td>
</tr>
<tr>
<td><strong>Chief Title:</strong> Chief Medical Officer</td>
</tr>
</tbody>
</table>

IEHP Provider Policy and Procedure Manual 01/20 MC_14H
Medi-Cal
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. 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.

B. Hospice care is 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 cure or prolongation of life. Palliative care does not require the Member to have a life expectancy of six (6) months or less and may be provided concurrently with curative care. 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.

C. Through the My Path Program, IEHP has expanded the eligibility criteria to include other advanced illness conditions and expanded the benefit to include Medi-Cal and non-delegated Medicare Members.

D. Disputes related to the provision of palliative services will comply with regulatory grievance and appeal requirements. Please see Policy 16A, “Member Grievance and Appeals Resolution Process” for more information.

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. 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,
I. My Path Palliative Care Program

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-life care and is for “any age and any stage” of illness.  

PROCEDURES:

A. Program Overview

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

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5 Department of Health Care Services’ Senate Bill 1004 Medi-Cal Palliative Care Policy (November 2017).
6 DHCS APL 18-020.
14. UTILIZATION MANAGEMENT

I. My Path Palliative Care Program

all authorized palliative care, including but not limited to pain and symptom management and chronic disease management. The plan of care must not include 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 with 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.
14. UTILIZATION MANAGEMENT

I. My Path Palliative Care Program

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. This is located on the web at www.iehp.org.

7 DHCS APL 18-020.
I. My Path Palliative Care Program

C. Member Identification

1. Eligible Members will be identified, assessed for program eligibility, and referred to the My Path Program through multiple means.
   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 out to these Members and perform a 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 a 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.

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.  
   f. Audit scope will include but not be limited to: 
      1) Requirements under the current All Plan Letter;
      2) Quality of Care Standards; and

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8 DHCS APL 18-020.
14. UTILIZATION MANAGEMENT

I. My Path Palliative Care Program

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 Attachment, “My Path Palliative Care Program CAP Form” in Section 14) 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.
14. UTILIZATION MANAGEMENT

I. My Path Palliative Care Program

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.
# 14. UTILIZATION MANAGEMENT

## Attachments

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>POLICY CROSS REFERENCE</th>
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<tbody>
<tr>
<td>Acute Inpatient Data Sheet</td>
<td>14G</td>
</tr>
<tr>
<td>Health Plan Referral Form for Out-of-Network and Special Services</td>
<td>14D, 14E, 25E1</td>
</tr>
<tr>
<td>Long Term Care (LTC) Follow-up Review Form</td>
<td>14F1, 14F2</td>
</tr>
<tr>
<td>Long Term Care (LTC) Initial Review Form</td>
<td>14F1, 14F2</td>
</tr>
<tr>
<td>MC 171 Form and Instruction 05-07</td>
<td>14F2</td>
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<tr>
<td>My Path Palliative Care Program CAP Form</td>
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<td>Optional Benefits Grid</td>
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<td>Referral Tracking Log</td>
<td>14A1, 14A2, 14B</td>
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<tr>
<td>Specialty Office Service Auth Sets Grid</td>
<td>14D</td>
</tr>
<tr>
<td>Standing Referral / Extended Access Referral to Specialty Care</td>
<td>14A3</td>
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## Acute Inpatient Data Sheet
(20 Day Stays and Greater)

Please fax reviews on day 20 and weekly thereafter to 909-477-8553.

<table>
<thead>
<tr>
<th>IPA Name</th>
<th>Date Submitted</th>
<th>Submitted By</th>
<th>Contact Number</th>
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### Member Information

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Member ID</th>
<th>Age / Gender</th>
<th>Facility Name</th>
<th>Admission / Enrollment Date</th>
<th>Attending Physician</th>
<th>Clinical Summary (e.g. Presenting DX, Co-morbidities/complications resulting in extended stay)</th>
<th>Discharge Plan</th>
<th>If out-of-area/network, explain? *See Legend</th>
<th>Comments</th>
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*Legend:

CC = Care Coordination
COC = Continuity of Care
HLOC = Higher Level of Care
ED = Emergency Department Admit
NBAN = No Bed Available in Network
This form is for services requiring health plan review.

1. Referrals

DATE: ___________________________________  (TO BE COMPLETED BY IEHP)

- EXPEDITED - Decision w/in 72 hours
- ROUTINE
- PATIENT REQUESTED
- RETRO
- CBAS
- CPO Services

AUTH/TRACKING NUMBER: __________________________

AUTH/EXPIRATION DATE: ___________________________

2. General Information

Member Name (please print)  DOB  ID #

Plan (select one)
- Medi-Cal
- Healthy Families
- Non-State Programs
- Open Access
- Medicare

Address  City  Zip  Phone

Diagnosis (Required)

Clinical justification for referral and description of procedure requested if any (Required) (attach clinical information). When requesting services out-of-network, please provide documentation of failed attempts at in-network providers/facilities.

Diagnosis Code (REQUIRED)

Referred to (must refer to a specialist within network)

Specialty:  NPI#:  Phone

Address:  City:  Zip:  Fax

Referring Provider (please print)

Phone  Fax

Address  City  Zip

Referring Provider Signature (REQUIRED)  NPI#  Date

3. Service Requested

Service Requested (check one)
- Consult
- Follow-up
- DME
- Home Health
- Other

Service Location/Facility:
- Office
- Outpatient
- Inpatient

Procedure Requested (Submit supportive documentation with the claim to justify the Evaluation and Management (E & M) code if this service will occur the same day as the procedure.)

CPT Code (REQUIRED)

Facility Address  Phone  Fax

4. Completed by IEHP

Date Additional Information Required:  Date Additional Information Received:

- Approved
- Modified
- Other

Assigned IPA:

Medical Reviewer Comments

Medical Reviewer Signature (Circle Title: MD, DO, RN, LVN, Coordinator)  Date

Criteria utilized in making this decision is available upon request by calling IEHP (866) 725-4347.

UPON ACCEPTANCE OF REFERRAL AND TREATMENT OF THE MEMBER, THE PHYSICIAN/PROVIDER AGREES TO ACCEPT IEHP CONTRACTED RATES. THIS REFERRAL/AUTHORIZATION VERIFIES MEDICAL NECESSITY ONLY. PAYMENTS FOR SERVICES ARE DEPENDENT UPON THE MEMBER’S ELIGIBILITY AT THE TIME SERVICES ARE RENDERED.

FAX COMPLETED REFERRAL FORMS TO (909) 890-5751
ATTACHMENT 14 - HEALTH PLAN REFERRAL FORM
OUT-OF-NETWORK PROVIDERS/SPECIAL SERVICES

NOTICE: This facsimile contains confidential information that is being transmitted to and is intended only for use of the recipient named above. Reading, disclosure, discussion, dissemination, distribution, or copying of this information by anyone other than the named recipient or his or her employees or agents is strictly prohibited. If you have received this facsimile in error, please immediately destroy it and notify us by telephone at (866) 725-4347.

FAX COMPLETED REFERRAL FORMS TO (909) 890-5751
**LTC FOLLOW-UP REVIEW**

Please fax completed form to your facility’s assigned IEHP Nurse.

All questions contained in this questionnaire are strictly **confidential** and will become part of the Member’s medical record.

**Facility:**

**Name (Last, First, M.I.):**

**DOB:**

**Reference #**

**ID #:**

**Activity Level:**

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<th>Weight:</th>
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<tbody>
<tr>
<td>DCP:</td>
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<tr>
<td>☐ LTC</td>
<td>☐ B&amp;C</td>
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**Cognitive Status Alert/Oriented:**

| ☐ x1 | ☐ x2 | ☐ x3 | ☐ x4 |

**Criteria Met for Continued Stay:**

<table>
<thead>
<tr>
<th>☐ Yes</th>
<th>☐ No</th>
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<tbody>
<tr>
<td>If yes, please describe deficit:</td>
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**Behavioral Change:**

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<thead>
<tr>
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</tr>
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<tr>
<td>If yes, please describe:</td>
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**Dietary Change:**

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<thead>
<tr>
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<th>☐ No</th>
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<tbody>
<tr>
<td>If yes, please describe:</td>
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**Medical Change:**

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<tr>
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<td>If yes, please describe:</td>
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**Medication Change:**

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<tbody>
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<td>If yes, please describe:</td>
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**Skin Condition Change:**

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<tr>
<td>If yes, please describe:</td>
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**Any Falls Since Last Review:**

<table>
<thead>
<tr>
<th>☐ Yes</th>
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<tr>
<td>If yes, please describe:</td>
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**Does SNF Facility Provide Transportation?:**

<table>
<thead>
<tr>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
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<tbody>
<tr>
<td>If no, please indicate needs:</td>
<td></td>
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</table>

### CONTINUED CARE NEEDS

**Resident Care Needs (Check all conditions that apply):**

<table>
<thead>
<tr>
<th>☐ Chemo</th>
<th>☐ Eloper/Wanderer</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Colostomy</td>
<td>☐ Foley Cath</td>
</tr>
<tr>
<td>☐ Coma</td>
<td>☐ G/J Tube</td>
</tr>
<tr>
<td>☐ Dialysis</td>
<td>☐ HHN</td>
</tr>
<tr>
<td>☐ O2</td>
<td>☐ Trach</td>
</tr>
<tr>
<td>☐ Other:</td>
<td>☐ Surgical</td>
</tr>
<tr>
<td>☐ Arterial</td>
<td>☐ Pressure</td>
</tr>
<tr>
<td>☐ Venous</td>
<td>Wounds</td>
</tr>
<tr>
<td>☐ Stage(s):</td>
<td></td>
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**Activity Level**

<table>
<thead>
<tr>
<th>Bed Mobility</th>
<th>☐ Max</th>
<th>☐ Mod</th>
<th>☐ Min</th>
<th>☐ Assist</th>
<th>☐ Independent</th>
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<tbody>
<tr>
<td>Supine to Sit</td>
<td>☐ Max</td>
<td>☐ Mod</td>
<td>☐ Min</td>
<td>☐ Assist</td>
<td>☐ Independent</td>
</tr>
<tr>
<td>Sit to Supine</td>
<td>☐ Max</td>
<td>☐ Mod</td>
<td>☐ Min</td>
<td>☐ Assist</td>
<td>☐ Independent</td>
</tr>
</tbody>
</table>

Indicate all appropriate assistive device(s) Member uses:

- ☐ Wheelchair
- ☐ Cane
- ☐ Walker
- ☐ Other

- Gait Distance x ft.
- Wheelchair Mobility x ft.
- Safety/Balance ☐ Good ☐ Fair ☐ Poor
- Endurance ☐ Good ☐ Fair ☐ Poor
- Dressing Upper Body ☐ Min ☐ Mod ☐ Max Assist ☐ Independent
- Dressing Lower Body ☐ Min ☐ Mod ☐ Max Assist ☐ Independent
- Toileting ☐ Min ☐ Mod ☐ Max Assist ☐ Independent
- Bathing ☐ Min ☐ Mod ☐ Max Assist ☐ Independent
- Personal Hygiene ☐ Min ☐ Mod ☐ Max Assist ☐ Independent

**Treatment Goals Set:**

**Treatment Goals Met:**

**Comments/Other (e.g. Specialty Consultation):**

**Updates to Discharge Plan:**

Date of Review       Nurse Reviewer Printed Name       Nurse Reviewer Signature       Contact Phone Number
**SNF INITIAL REVIEW**

Please fax completed form to your facility’s assigned IEHP Nurse.

All questions contained in this questionnaire are strictly **confidential** and will become part of the Member’s medical record.

<table>
<thead>
<tr>
<th>Name (Last, First, M.I.)</th>
<th>DOB:</th>
<th>Auth #</th>
<th>Admission Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility:</td>
<td></td>
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<tr>
<td>Admit Dx:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-Morbidities:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admit Level of Care:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Justification for Level:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>DCP:</td>
<td></td>
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<td></td>
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<tr>
<td>Current Barriers to DCP:</td>
<td></td>
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<td></td>
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<tr>
<td>Treatment Goals:</td>
<td></td>
<td></td>
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<tr>
<td>Prior Living Conditions:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior Level of Function:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does Member have social or family support?</td>
<td>Yes</td>
<td>No</td>
<td>Describe:</td>
</tr>
<tr>
<td>Does Member own DME?</td>
<td>Yes</td>
<td>No</td>
<td>Type?</td>
</tr>
<tr>
<td>Does Member have income?</td>
<td>Yes</td>
<td>No</td>
<td>How much per month?</td>
</tr>
<tr>
<td>Does Member Have an Advance Directive or Living Will?</td>
<td>Yes</td>
<td>No</td>
<td>DPOA:</td>
</tr>
<tr>
<td>Does SNF Facility Provide Transportation?</td>
<td>Yes</td>
<td>No</td>
<td>Other:</td>
</tr>
<tr>
<td>Indicate Transportation Needs:</td>
<td>O2</td>
<td>Cane</td>
<td>Gurney</td>
</tr>
<tr>
<td>Does Member have the potential to go back home when ready for discharge?</td>
<td>Yes</td>
<td>No</td>
<td>If No, Why?</td>
</tr>
</tbody>
</table>

**PATIENT SUPPORT/CAREGIVER**

<table>
<thead>
<tr>
<th>Name (Last, First, M.I.)</th>
<th>Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Email:</td>
</tr>
<tr>
<td>Party to Sign Contract:</td>
<td></td>
</tr>
<tr>
<td>Home Number:</td>
<td>Cell Number:</td>
</tr>
<tr>
<td>Work Number:</td>
<td></td>
</tr>
</tbody>
</table>

**PERSONAL SAFETY & ACTIVITY LEVEL**

- Dietary Requirements/Restrictions:
  - Chemo
  - Eloper/Wanderer
  - Ileostomy
  - O2
  - Trach
  - Colostomy
  - Foley Cath
  - Isolation
  - Smoker
  - Other: __________
  - Coma
  - G/J Tube
  - NG Tube
  - Radiation
  - Suctioning/Frequency: ________
  - Dialysis/Days
  - HHN
  - NPO
  - TPN

- Personal Safety
  - Does Member have stairs at home? Yes No How Many: ________
  - Does Member experience frequent falls? Yes No
  - Does Member have vision or hearing loss? Yes No
  - Indicate all appropriate assistive device(s) Member uses:
    - Wheelchair
    - Cane
    - Walker
    - Other
    - Ambulation x ft. Independent Max Assist Mod Min
    - Safety/Balance Good Fair Poor

**Discharge Plan:**

**ADMISSION PACKET CHECKLIST** (PLEASE SEND WITH ALL NEW)

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facesheet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Orders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IFT (Inter-facility transfer form)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MC171 (Custodial)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDS (Custodial)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEDICATIONS (EXCLUDING PRN) PLEASE INCLUDE SEPARATE SHEET, IF NECESSARY.**

<table>
<thead>
<tr>
<th>Name the Drug(s):</th>
<th>Strength:</th>
<th>Frequency Taken:</th>
</tr>
</thead>
</table>

Date of Review Nurse Reviewer Printed Name Nurse Reviewer Signature Contact Phone Number
# MEDI-CAL LONG-TERM CARE FACILITY ADMISSION AND DISCHARGE NOTIFICATION
(Instructions and distribution on reverse.)

## I. COMPLETE THIS PORTION FOR ALL ACTIONS

<table>
<thead>
<tr>
<th>Patient’s name (last)</th>
<th>(first)</th>
<th>(MI)</th>
<th>Name of facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social security number</td>
<td></td>
<td></td>
<td>Address (number and street)</td>
</tr>
</tbody>
</table>

Note: Level of care is SNF/ICF unless checked here as board and care. 

## II. COMPLETE THIS PORTION ONLY FOR ADMISSIONS

<table>
<thead>
<tr>
<th>Medi-Cal ID number (taken from the Medi-Cal card)</th>
<th>Admission date (month/day/year)</th>
</tr>
</thead>
</table>

A. Do you have Medicare Part A, Hospital Coverage?  
   - [ ] Yes  
   - [ ] No

B. Expected length of stay:  
   - [ ] At least one full month after the month of admission  
   - [ ] Less than one full month after the month of admission

C. Medi-Cal is expected to pay over 50% of facility cost of care.  
   - [ ] Yes, beginning with month of ______, 20____  
   - [ ] No, other insurance, private pay, etc.

D. Current income (check all applicable boxes):  
   - [ ] Supplemental Security Gold Checks  
   - [ ] Social Security Green Checks  
   - [ ] Other Income (i.e., railroad, military retirement, etc.)  
   - [ ] None

E. Admission from:  
   - [ ] Home  
   - [ ] Board and Care  
   - [ ] Household of another  
   - [ ] Acute Hospital—Home, B&C, other household immediately prior to acute  
   - [ ] Acute Hospital—SNF/ICF immediately prior to acute  
   - [ ] Acute Hospital extended stay—over 30 days  
   - [ ] Another SNF/ICF

F. If known, enter your address prior to facility admission. If admitted from an acute hospital, enter your address prior to the acute hospital admission. (Do not give the acute hospital’s address.)

<table>
<thead>
<tr>
<th>Address (number and street)</th>
<th>City</th>
<th>State</th>
<th>ZIP code</th>
</tr>
</thead>
</table>

G. Signature of recipient or representative payee or family member/other:

<table>
<thead>
<tr>
<th>Signature of recipient</th>
<th>Signature of Representative Payee</th>
<th>Phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If recipient’s signature cannot be obtained, please indicate reason in this space.

<table>
<thead>
<tr>
<th>Signature of family member/other (Indicate your relationship to the recipient.)</th>
<th>Phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

## III. COMPLETE THIS PORTION ONLY FOR DISCHARGES

A. Reason for discharge:  
   - [ ] Discharged to Acute Hospital  
   - [ ] Discharged to another SNF/ICF  
   - [ ] Discharged to residence/home of another  
   - [ ] Discharged to Board and Care  
   - [ ] Discharged to other  
   - [ ] Discharge due to death

B. Date of discharge (month/day/year)

C. Medi-Cal ID number (taken from the Medi-Cal card)

D. Complete the forwarding address for discharges other than death:

<table>
<thead>
<tr>
<th>Name of facility (if not discharged home)</th>
<th>Address (number and street)</th>
<th>City</th>
<th>State</th>
<th>ZIP code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Facility representative signature  

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>
I. General Instructions

This form is to be used for each admission and discharge. Please do not use this form for Medi-Cal reauthorizations.

II. Admission Instructions

A. Preparation

Prepare an original and two copies of this form for each SSI/SSP and/or Medi-Cal admission.

B. Distribution

Original: Send to your local social security office for recipients with aid codes 10, 20, and 60. Send to the county welfare department (see attached list) for all other aid codes.

Copy 1: Attach to the Treatment Authorization Request (TAR) and send to the Department of Care Health Services, Medi-Cal field office in your area. It will be forwarded by the Medi-Cal field office to the county welfare department.

Copy 2: Retain for your file.

III. Discharge Instructions

A. Preparation

Prepare an original and two copies of this form for each SSI/SSP and/or Medi-Cal discharge. Instead of completing a new form, use copy two of the form retained in your file as part of the admissions process. Complete Part III of the form (which becomes the original for the discharge process), and make two copies.

B. Distribution

Original: Send to the Medi-Cal field office.

Copy 1: Send to the county welfare department (see attached list).

Copy 2: Retain for your file.

IV. Explanation of over 50% of cost of care mentioned in item II.C. of this form.

Cost of care is the daily charge per patient excluding any additional services rendered to the patient which are billed separately by other providers (i.e., ambulance, physician, pharmacy, etc.).

For example, if the daily rate is $30 per day, the monthly charge for a 30-day month would be $900. If a patient enters the facility during the month of January, and is expected to stay at least one full calendar month after the month of admission (through February), a “YES” response would be indicated for item II.C. if Medi-Cal is expected to pay over $450 of the $900 charge for February.
Corrective Action Plan (CAP) Form
Original Date Sent to My Path Provider: Click here to enter a date.

Please complete the Root Cause Analysis, Action Plan, Monitoring Plan, and sign and date in the spaces provided below. This CAP is due to IEHP within 30 calendar days of receipt. If you have any questions regarding this CAP, please contact IEHP My Path Team at: dgmypathteam@iehp.org

<table>
<thead>
<tr>
<th>File Month/Year</th>
<th>Type</th>
<th>Findings</th>
<th>Root Cause Analysis (to be completed by Provider)</th>
<th>Action Plan (to be completed by Provider)</th>
<th>Monitoring Plan (to be completed by Provider)</th>
<th>CAP Accepted (Y/N)</th>
<th>Comments</th>
</tr>
</thead>
</table>

I understand that I have a responsibility to report any areas where activities are not in place to meet the actions or monitoring noted above, and that an additional audit by the health plan may be undertaken to ensure compliance.

Printed Name of Individual Attesting to CAP Response

Title of Signing Individual
Signature of Individual Attesting to CAP Response

Date
**OPTIONAL BENEFITS GRID**

The purpose of the following grid is to ensure uniformity across the health plan regarding the adjudication of authorization requests for eliminated and/or optional Medi-Cal benefits for adults. This grid should also serve as a guide for those services that may be approved for medical necessity. Please bear in mind that for Medi-Cal, the law considers a beneficiary an adult on their 21st birthday. Medi-Cal beneficiaries who are not yet 21 continue to have the optional benefits covered.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Covered for Medical Necessity</th>
<th>No longer covered</th>
</tr>
</thead>
</table>
| Optometry    | 1. Routine eye exams once every 24 months.  
                   2. Diabetic retinal exams.                                                               | Optometry – glasses/contacts and TPA services **will not be covered** for our adult Medi-Cal Members                                              |
| Podiatry*    | 1. Medically necessary foot care for diabetics or other illnesses may be covered on a case by case basis.  
                   (Matrixectomy should be covered along with any conditions that may lead to hospitalization if lower level care is not rendered.)  
                   2. Orthotics are covered when medically necessary.  
                   3. All Medi-Cal podiatric services are covered when provided by Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs). | Podiatry – routine podiatry services  
                   • Routine nail trimming without evidence of a disease process.  
                   • Bunions, plantar fasciitis consults when no conservative therapy has been attempted.  
                   IEHP may restrict reimbursement to contracted FQHC/RHC providers, except as required by current out-of-network provider services policies. |
| Speech Therapy | Speech Therapy – medically necessary services may be covered on a case by case basis, e.g., swallowing evaluation or speech therapy for a post-stroke patient |                                                                                                                                                    |
| Incontinence therapies | Incontinence Creams and Washes – will be covered.                                          |                                                                                                                                                  |
| Audiology    | Medically necessary services may be covered on a case by case basis. Hearing aids **are still a benefit** and an audiogram is required to verify that the hearing loss is significant enough to justify the device. |                                                                                                                                                  |
*Podiatry*
IEHP covers all medically necessary foot care and Podiatry (specialist in the treatment of disorders of the foot) services for Members who are diabetic (a condition that causes high blood sugar levels in the blood) and need diabetic foot care, or for removal of ingrown toenail. IEHP also covers all Podiatry services that are provided by contracted Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs). The medical information received from your doctor does not indicate you are diabetic or have an ingrown nail.

Please follow-up with your doctor for additional treatment options.
## PCP Referral Tracking Log

<table>
<thead>
<tr>
<th>Date Referral Sent to IPA</th>
<th>Member Name &amp; Date of Birth</th>
<th>Acuity of Referral*</th>
<th>Reason for Referral/Dx</th>
<th>Service or Activity Requested</th>
<th>Date Auth. Received</th>
<th>Referral Decision**</th>
<th>Patient Notified</th>
<th>Date Appt or Service</th>
<th>Date Consult Report Rec’d or Outreach Effort</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

* Acuity of Referral: Emergent, Urgent or Routine

** Decision: Approved, Modified or Denied
# Referral Tracking Log

<table>
<thead>
<tr>
<th>IPA Auth/Tracking number</th>
<th>Member Name</th>
<th>IEHP ID Number</th>
<th>Member DOB</th>
<th>Acuity of Referral*</th>
<th>Reason for Referral/DX</th>
<th>Service/Activity Requested</th>
<th>Date Rec'd from IPA</th>
<th>Requesting Provider</th>
<th>Requested Provider</th>
<th>Requested Prov Specialty</th>
<th>Referral decision**</th>
</tr>
</thead>
</table>

*Acuity of Referral: Urgent, Routine, Urgent Concurrent or Retrospective*

**Decision: Approved, Modified, or Denied**
### SPECIALTY OFFICE SERVICE AUTHORIZATION SETS

These procedures are to be performed in the office only. Specialty referral includes consult and up to two (2) follow-up visits unless otherwise noted and may include:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy - Skin Testing for 80 or Fewer Tests</td>
<td>95004 X up to 80</td>
</tr>
<tr>
<td>CARD – EKG (Adult &amp; Peds)</td>
<td>93000</td>
</tr>
<tr>
<td>CARD – Routine Stress Treadmill (Adult)</td>
<td>93015</td>
</tr>
<tr>
<td>CARD – Holter Monitor (Adult &amp; Peds)</td>
<td>93235</td>
</tr>
<tr>
<td>CARD – Echocardiogram (Peds only)</td>
<td>93303 or 93307 + 93320 + 93325</td>
</tr>
<tr>
<td>DERM – Punch Biopsy</td>
<td>11100</td>
</tr>
<tr>
<td>DERM – Cryotherapy of Lesions</td>
<td>17000, 17003, 17110</td>
</tr>
<tr>
<td>DERM – Excision of Nail &amp; Nail Matrix</td>
<td>11750</td>
</tr>
<tr>
<td>NEURO - EEG Standard</td>
<td>95816 or 95819</td>
</tr>
<tr>
<td>ENDO – Urinalysis</td>
<td>81003 or 82948</td>
</tr>
<tr>
<td>ENDO – Glucose/Blood</td>
<td>82947</td>
</tr>
<tr>
<td>ENDO – Fine Needle Aspiration of Thyroid</td>
<td>10021-10022</td>
</tr>
<tr>
<td>ENT – Tympanogram</td>
<td>92567</td>
</tr>
<tr>
<td>ENT – Pure Tone Audiogram</td>
<td>92557, 92582</td>
</tr>
<tr>
<td>ENT – Cerumen Removal</td>
<td>69210</td>
</tr>
<tr>
<td>ENT – Nasal Cauterization Treatment of Epistaxis (Anterior or Posterior)</td>
<td>30901, 30905</td>
</tr>
<tr>
<td>ENT – Nasal Endoscopy</td>
<td>31231, 31238</td>
</tr>
<tr>
<td>ENT – Removal of Foreign Body Ear or Nose</td>
<td>69200, 30300</td>
</tr>
<tr>
<td>ENT – Streptococcus A Screen</td>
<td>87880</td>
</tr>
<tr>
<td>Gastroenterology – Flex Sigmoidoscopy</td>
<td>45330</td>
</tr>
<tr>
<td>GYN – Urine Pregnancy Test</td>
<td>81025</td>
</tr>
<tr>
<td>GYN – Depo-Provera</td>
<td>X6051</td>
</tr>
<tr>
<td>Procedure</td>
<td>CPT Code</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>GYN – Abnormal Pap Follow-Ups <em>and:</em></td>
<td>99213-99215 (X 3)</td>
</tr>
<tr>
<td>Colposcopy with Biopsy</td>
<td>57452 or 57454-455, 57460</td>
</tr>
<tr>
<td>Endometrial Biopsy</td>
<td>58100, 58558</td>
</tr>
<tr>
<td>LEEP</td>
<td>57460</td>
</tr>
<tr>
<td>Hematology - Bone Marrow Bx and/or Aspiration</td>
<td>38221, 38220</td>
</tr>
<tr>
<td>Hematology – Blood Smears</td>
<td>86007-85008</td>
</tr>
<tr>
<td>Nephrology – Urinalysis</td>
<td>8100-81003</td>
</tr>
<tr>
<td>Orthopedics – Total Fracture Care (Watch for CCS) X 6 mos.</td>
<td>By site of injury By date of service</td>
</tr>
<tr>
<td>Orthopedics – X-Rays, in office simple extremity</td>
<td>73000-73140</td>
</tr>
<tr>
<td>Orthopedics – Casting, Splints</td>
<td></td>
</tr>
<tr>
<td>Orthopedics – DME (boot, shoe, crutches)</td>
<td></td>
</tr>
<tr>
<td>Orthopedics – Joint aspiration</td>
<td>20600-20615</td>
</tr>
<tr>
<td>Orthopedics – Trigger point injections</td>
<td></td>
</tr>
<tr>
<td>Injection of Tendon &amp; Ligament</td>
<td>20550-20553</td>
</tr>
<tr>
<td>Injection of Bursa</td>
<td>20600, 20605, 20610</td>
</tr>
<tr>
<td>Podiatry – Matrixectomy</td>
<td>11750</td>
</tr>
<tr>
<td>Podiatry – Debridement of Nails</td>
<td>11720-11721</td>
</tr>
<tr>
<td>Pulmonary – Spirometry</td>
<td>94010, 94060</td>
</tr>
<tr>
<td>Pulmonary – Blood Gases</td>
<td>82800-82810</td>
</tr>
<tr>
<td>Radiology - Mammogram</td>
<td>77057</td>
</tr>
<tr>
<td>- Breast Ultrasound @ radiologist suggestion</td>
<td>76645</td>
</tr>
<tr>
<td>- Cone View</td>
<td>77055</td>
</tr>
<tr>
<td>Rheumatology – T.P Injection</td>
<td>20552</td>
</tr>
<tr>
<td>Rheumatology – Injection of Tendon &amp; Ligament</td>
<td>20550-20553</td>
</tr>
<tr>
<td>Rheumatology – Joint Aspiration</td>
<td>20600-20615</td>
</tr>
<tr>
<td>Surgery – Breast Biopsy</td>
<td>77031</td>
</tr>
<tr>
<td>Surgery – I &amp; D of Cutaneous Abscess</td>
<td>10060-10061</td>
</tr>
<tr>
<td>Urology – Urinalysis</td>
<td>81000-81003</td>
</tr>
<tr>
<td>Urology - Cystoscopy</td>
<td>52000</td>
</tr>
</tbody>
</table>
## Standing Referral / Extended Access Referral to Specialty Care Request

**Date of Request**

**IPA/MG**

**PCP**

**Phone #**

**Phone #**

**FAX**

**Requesting MD**

**Phone #**

**FAX**

**Other Insurance**

**Phone #**

**Member Name**

**DOB**

**M**

**F**

**Phone #**

**Address**

**City**

**State**

**ZIP**

**Member ID #**

**Referral To (Physician Name):**

**Type of Specialist:**

**Phone #**

**FAX**

**Diagnosis Primary**

**ICD 10**

**Diagnosis Secondary**

**ICD 10**

### **Practitioner Treatment Plan** (Complete or attach)

<table>
<thead>
<tr>
<th># Visits/Period</th>
<th>Visits/3 Months</th>
<th>Visits/6 Months</th>
<th>Visits/9 Months</th>
<th>Visits/1 Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Requested (fill in number of visits)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Briefly, describe what is anticipated on each visit:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

When was the diagnosis first made? ________________________________

How many times has the patient been seen by the Specialist in the past year? __________

Additional information regarding treatment plan may be requested from the Specialist if necessary. If so, decision will be made within three (3) business days of receipt of the information. Authorization remains valid only if Member is eligible. Payment is contingent upon the patient’s eligibility at the time service is rendered.