
12. COORDINATION OF CARE

- A. Care Management Requirements
 - 1. IEHP Responsibilities
-

APPLIES TO:

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

POLICY:

- A. IEHP is responsible for primary case management (CM) of Medicare DualChoice (HMO SNP) Members. CM responsibilities include the following minimum set of activities: case finding, care coordination, referral for services, case follow-up, and other CM activities as required.
- B. IEHP is responsible for coordinating care when IEHP Medicare DualChoice (HMO SNP) Members move from one setting to another, such as between the ambulatory and inpatient settings, including verification that the Member is accessing care at the assigned facility.
- C. IEHP is responsible for hospital discharge planning and effective transitions of care for IEHP Medicare DualChoice (HMO SNP) Members.
- D. IEHP requires that the Standards of Practice for Case Management, published by the Case Management Society of America, be used as a guideline for CM (see Attachment 12-1 in Section 12, “Attachments”).
- E. IEHP CM staff must include licensed medical personnel.
- F. For management of IEHP Medicare DualChoice (HMO SNP) Members, IEHP shall provide services initially under Member’s Medicare coverage. In an effort to maximize the Member’s benefits, Medi-Cal benefits will be applied to supplement Medicare coverage.
- G. IEHP coordinates the delivery of services covered by Medicare DualChoice (HMO SNP) Members through the following:
 - a. Helping Members access network providers that participate in both Medicare and Medi-Cal;
 - b. Educating providers about coordinating the Member’s Medicare and Medi-Cal benefits for which the Member is eligible and covers the Member’s special needs; and
 - c. Helping Members obtain services funded by either program when assistance is needed.

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A. Care Management Requirements

1. IEHP Responsibilities

PROCEDURE:

Case Management

- A. IEHP CM responsibilities include the follow-up and provision of CM services for members referred by PCPs. Examples of Members potentially requiring CM could include:
1. Members with complex medical conditions requiring multiple practitioners or multiple interventions;
 2. Members with specific illnesses such as tuberculosis or HIV that require coordination with out-of-network practitioners as outlined in Policies 10H, “HIV Testing and Counseling” and 10I, “Tuberculosis Services”;
 3. Potential California Children’s Services (CCS) cases or Inland Regional Center (IRC) cases as outlined in Policies 12B, “California Children’s Services (CCS)” and 12F, “Developmental Disabilities”;
 4. Potential major organ transplant candidates as outlined in Policy 12C, “Organ Transplant”;
 5. Members with suspected or confirmed developmental disabilities as outlined in Policy 12F, “Developmental Disabilities”;
 6. Members frequently accessing Emergency Room services;
 7. Members with suspected or confirmed substance abuse problems as described in Policy 12D2, “Alcohol and Drug Treatment Services”;
 8. Members with significant behavioral health problems as described in Policy 12D1, “Behavioral Health Services”;
 9. Members with high-risk pregnancies;
 10. Members who are non-compliant with their medical regimen; and
 11. Any other Member that could benefit from CM services.
- B. IEHP Care Managers are responsible for the following:
1. Coordination of care for Members;
 2. Follow-up on Members referred to specialists;
 3. Implementation of a Care Plan;
 4. Telephonic monitoring and written documentation of CM provided to low, moderate and high risk Members;
 5. Ensuring PCPs have documentation on Members receiving services from external

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A. Care Management Requirements

1. IEHP Responsibilities

- resources/practitioners (CCS or IRC); and
6. Providing copies of Member care plans to PCP.
- C. Inpatient CM - IEHP must provide inpatient CM that includes evaluation and assessment of hospitalized Members for social service problems; transitions in level of care including transfer to other facilities, Skilled Nursing Facility (SNF) placement, home health arrangements, and hospice referral; identification of needs and arrangements for durable medical equipment; and assistance with other referrals as necessary.
1. Outpatient CM - IEHP must provide CM in the outpatient setting for IEHP Medicare DualChoice (HMO SNP) Members that includes case finding, identification, coordination and management of referrals, identification of resources; case follow-up; arrangements for transportation, and interventions as necessary.
 2. For IEHP Medicare DualChoice (HMO SNP) Members receiving services from CCS, the PCP is responsible for continuing all medically necessary health care other than the CCS eligible condition.
 1. The IEHP Case Manager follows CCS referred cases throughout the treatment processes and assists with coordination and continuity of care.
 2. CCS is responsible for CM of CCS eligible conditions. Refer to Policy 12B, "California Children's Services (CCS)" for more information.
- D. IEHP Care Managers must assist network physicians in the medical CM of IEHP Medicare DualChoice (HMO SNP) Members identified with special needs.
1. IEHP Care Managers develop a Member care plan and follow such Members throughout the span of their CM needs.
 2. IEHP Care Managers assist treating physicians with continuity of care in both the inpatient and outpatient settings, for transitions between practitioners and Member support programs, and to ensure that the flow of medical information is continuous and unimpeded between practitioners.
- E. IEHP must maintain procedures to coordinate information between inpatient admitting physicians and PCPs to ensure continuity of care.

Referrals and Follow-Up Care

- A. IEHP Care Managers are required to perform necessary follow-up in a timely manner for referrals that are not **provided directly by the PCP**. Activities include, but are not limited to:
1. Initiating additional referrals for specialty services based on evaluation by the specialist practitioner;

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A. Care Management Requirements

1. IEHP Responsibilities

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2. Facilitating transfer of treatment information from the specialist to the PCP if not provided directly to the PCP by the specialty practitioner;
 3. Providing coordination of care and CM services necessary for the care of the Member (e.g., CCS, etc.); and
 4. Communication to the PCP, specialist, and Member.

Coordination of Care—Ambulatory to Inpatient and Discharge Planning

- A. IEHP is responsible for authorizing, arranging and coordinating hospital admissions.
- B. IEHP is responsible to ensure continuity of care from the ambulatory care setting to inpatient care for Members.
- C. IEHP Care Managers provide the coordination of care services for Members who need to be transitioned from the ambulatory care setting to inpatient care.
- D. IEHP Care Managers coordinate with the Member's PCP to ensure the Member is admitted to the appropriate level of care in the appropriate setting. IEHP assists the PCP in directing the Member to the assigned Hospital or contracted long-term care/rehabilitation facility.
- E. IEHP Care Managers are responsible for educating their contracted PCPs of the correct procedures and authorization processes to admit Members.
- F. IEHP Care Managers are responsible for being knowledgeable of the Hospitals' contracted long-term care and rehabilitation facilities, such as the names, phone numbers, locations, and contact people.
- G. IEHP Care Managers are responsible for the transfer of necessary medical records as the Member goes from the ambulatory care setting to inpatient care.
- H. IEHP is expected to coordinate discharge-planning activities with hospital staff to ensure a smooth transition for the Member.
- I. IEHP is responsible for coordinating the discharge planning of IEHP Medicare DualChoice (HMO SNP) Members from the inpatient care setting. This includes determining the appropriate level of care at discharge:
 1. Long-Term Care Facility;
 2. Skilled-Nursing Facility;
 3. Convalescent Care;
 4. Rehabilitation Facility;
 5. Home Health Care; and
 6. Home without services.

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A. Care Management Requirements

1. IEHP Responsibilities

- J. IEHP is responsible for coordinating the transfer of clinical information from the Hospital to the appropriate entity (e.g., SNF, PCP, etc.) through one of the following mechanisms:
1. Facilitating clinician-to-clinician telephone contact as needed;
 2. Arranging for transfer of medical records as needed; or
 3. Contacting CM or other staff at the facility or entity providing post-discharge services (e.g., contacting Home Health Agency staff).
- K. IEHP is responsible for coordinating with Hospital CM/discharge planning staff to ensure a smooth transition for the Member. Activities include:
1. Confirming that the Member is discharged to or receives services from a Hospital contracted practitioner, if the Hospital is responsible for payment;
 2. Coordinating discharge medications as necessary (see Policy 11F “Emergency Department and Hospital Inpatient Discharge Medication Requirements);
 3. Facilitating are ordering any needed DME or supplies; and
 4. Coordinating ambulance or other transport services as necessary.
- L. In cases where the Member refuses to be discharged or transferred, IEHP is responsible for the following:
1. Issuing a denial letter for further inpatient services;
 2. Informing the Member, in concert with the Hospital, that the Member is financially responsible for services beyond those approved by the physician and IEHP; and
 3. Informing the Member that they can appeal the denial decision to IEHP.

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- A. Care Management Requirements
 - 2. PCP Role
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APPLIES TO:

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

POLICY:

- A. Primary Care Physicians (PCPs) are responsible for medical management of assigned Members.
- B. PCPs are responsible for informing IEHP Care Management (CM) of any Member that potentially may need CM.
- C. PCPs are responsible for coordinating care with IEHP CM, as needed.

PROCEDURE:

- A. PCPs are responsible for requesting CM services for assigned Members, when indicated.
- B. PCPs are responsible for identifying Members who potentially require CM services and notifying IEHP CM. Potential Members could include, but are not limited to:
 - 1. Members with complex medical conditions requiring multiple practitioners or multiple interventions;
 - 2. Members with specific illnesses such as tuberculosis, or HIV that require coordination with out-of-network practitioners as outlined in Policies 10H, “HIV Testing and Counseling” and 10I, “Tuberculosis Services”;
 - 3. Members with a suspected or confirmed significant chronic illness, serious acute illness, injury, or any child with a CCS eligible condition or IRC cases as outlined in Policies 12B, “California Children Services (CCS)” and 12F, “Developmental Disabilities”;
 - 4. Potential major organ transplant candidates as outlined in Policy 12C, “Organ Transplant”;
 - 5. Members with suspected or confirmed developmental disabilities as outlined in Policy 12F, “Developmental Disabilities”;
 - 6. Members frequently accessing Emergency Room services;
 - 7. Members with suspected or confirmed substance abuse problems per Policy 12D2, “Alcohol and Drug Treatment Services”;
 - 8. Members with significant behavioral health problems per Policy 12D1, “Behavioral Health Services”;

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A. Care Management Requirements 2. PCP Role

9. Members with high-risk pregnancies;
 10. Members who are non-compliant with their prescribed medical regimen; and
 11. Any other Member that could benefit from CM services.
- C. PCPs are responsible for coordinating care to the Member with IEHP CM including but not limited to contacting other clinicians or entities, facilitating transfer of medical records as necessary and initiating specialty referrals.

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12. COORDINATION OF CARE

A. Care Management Requirements

3. Identifying and Reporting Potential Abuse of IEHP Members

APPLIES TO:

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

POLICY:

- A. Primary Care Physicians (PCPs) are responsible for the overall health care of assigned Members including the identification and reporting of suspected child, dependent adult, or elder abuse cases.
- B. PCPs are responsible for informing IEHP of identified or suspected child, dependent adult, or elder abuse cases and filing reports with appropriate county agencies.

PROCEDURE:

- A. There are a variety of information sources available to network providers to help identify possible Member abuse cases that include the following:
1. Requests by an Emergency Room for authorization to treat an illness or injury of suspicious or questionable nature;
 2. Request by an Urgent Care Center for authorization to treat an illness or injury of suspicious or questionable nature;
 3. Hospitalization of a Member for suspicious trauma, illness, or injury;
 4. Office visits with Pediatricians, PCPs, and other health care practitioners that reveal unusual physical or emotional findings;
 5. Cases identified during the Utilization Management (UM) or Care Management (CM) process;
 6. Requests for assistance received by Member Services; or
 7. Calls to the After Hours Nurse Advice Line (NAL).
- B. Healthcare providers must be alert for signs of physical or mental abuse including, but not limited to, the following signs and symptoms:
1. Evidence of malnutrition, starvation, dehydration, a failure to thrive;
 2. Chronic neglect;
 3. Sexual assault;
 4. Exposure to controlled substances, street drugs, or alcohol;

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A. Care Management Requirements

3. Identifying and Reporting Potential Abuse of IEHP Members

5. Conflicting or inconsistent accounts of incidents and injuries;
6. Depression or suicidal thoughts;
7. Blunt force trauma;
8. Infection due to lack of medical treatment;
9. A series of accidents, bruises, or fractures over time; or
10. Unexplained illness or injury.

- C. IEHP network providers are responsible for filing reports of suspected abuse with the appropriate agencies as follows:

Riverside

Child Abuse:

Department of Public Social Services
Child Protective Services
(800) 442-4918 (24 hours)

San Bernardino

Child Abuse:

Children and Family Services
(909) 384-9233
(800) 827-8724 (24 hours)

Dependent Adult and Elder Abuse:

Department of Public Social Services
Adult Protective Services
(800) 491-7123 (24 hours)

Dependent Adult and Elder Abuse:

Department of Aging and Adult Services
Adult Protective Services
(877) 565-2020 (24 hours)

- D. IEHP is responsible for educating their contracted PCPs of the procedures for reporting abuse cases, case managing abuse cases, and verifying that reporting has occurred.

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B. California Children's Services (CCS)

APPLIES TO:

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

POLICY:

- A. Primary Care Physicians (PCPs) are responsible for the identification of children with potentially eligible conditions and subsequent referral of those children to the California Children's Services (CCS) program.
- B. PCPs and/or referral specialists are also responsible for notifying the IEHP Care Manager of Members referred to CCS. IEHP Care Managers are responsible for facilitating referrals and tracking outcomes.
- C. Medically necessary health care must continue to be administered by the PCP and IEHP throughout the referral process, regardless of whether or not the child is accepted into the CCS program. The PCP and IEHP are responsible for all medically necessary health care related to a potential CCS eligible condition until CCS establishes eligibility and issues a temporary number or an authorization number. The CCS program is only responsible for treatment and payment for CCS eligible conditions. PCPs and IEHP continue to be responsible for all other medically necessary care.
- D. For management of Medicare or Medi/Medi Members, IEHP shall provide services initially under Member's Medicare coverage. In an effort to maximize the Member's benefits, Medi-Cal benefits will be applied to supplement care coverage.

PROCEDURE:

- A. PCPs are responsible for identifying Members that may have eligible CCS conditions (see Attachment 12-2 in Section 12, "Attachments"). The identification can occur at any medical encounter including Well Child Visits, acute or chronic illness visits and 120-day assessments.
- B. Members with potential CCS conditions can also be identified in the following ways:
1. IEHP Utilization Management (UM) - Identification can occur through review of specialty or diagnostic referrals that suggest a CCS condition. IEHP UM is responsible for informing the IEHP CCS department and/or submitting the referral to the appropriate County CCS Program.
 2. IEHP Inpatient UM - Potential CCS cases may be directly identified during concurrent review, discharge planning or other activities.
 3. Upon identification of a Member with a potential CCS eligible diagnosis, the Inpatient UM Nurse can refer the Member to CCS for determination of medical

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B. California Children's Services (CCS)

eligibility. Identification can occur through Member Services (Member calls), grievances or through referral from IEHP Pharmacy Services.

4. Hospital CM or UM - Hospital based CM or UM staff may identify potentially eligible CCS cases during inpatient stays. Hospitals and IEHP Inpatient UM are responsible for coordination of referrals to the CCS program to ensure continuity of care.

- C. CCS provides diagnostic services, medical treatment and CM to children with conditions eligible for treatment under the CCS program. The PCP, IEHP UM/CM program, or referral specialist identifies and refers children with potential CCS eligible conditions to CCS for eligibility determination. If eligibility is not determined prior to expiration of the review time frames, IEHP must authorize services. CCS offers three program components:

1. Diagnosis and Treatment Program - Provides medically necessary care and CM to infants, children and adolescents meeting program eligibility requirements. CCS may authorize diagnostic services necessary to confirm a suspected CCS eligible condition if the referring physician's medical records support a high probability of presence of the suspected CCS condition. CCS cannot authorize diagnostic services to "rule-out" conditions.
2. Medical Therapy Program - Provides medically necessary physical therapy, occupational therapy to children who are medically eligible for CCS.
3. High Risk Infant Follow-up Program – Provider follow-up for infants discharged from a Neonatal Intensive Care Unit (NICU) who are at risk for developing a CCS eligible condition. These services include developmental testing, neurological, ophthalmologic and audiological evaluations.

- D. CCS accepts referral forms from individuals or entities. Therefore, PCPs, specialists or IEHP are responsible for the completion of referral forms (see Attachments 12-3a and 12-3b in Section 12, "Attachments"). The CCS referral form includes information including type of requested service, diagnosis, history and management plan, number of days requested, and specific NICU information when necessary. Applicable medical records and a request for CCS services should be submitted to one of the following entities:

Riverside County Residents
Riverside County CCS Program
10769 Hole Ave., Ste. 220
Riverside, CA 92505
Phone: (951) 358-5401
Fax: (951) 358-5198
Fax: (951) 358-5150
Fax: (951) 358-7905

San Bernardino Residents
San Bernardino County CCS Program
150 Carousel Mall
San Bernardino, CA 92415-0062
Phone: (909) 387-8400
Fax: (909) 387-8401

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B. California Children's Services (CCS)

- E. CCS sends a CCS program application and agreement to the Member, parent, or legal guardian. The PCP may assist with the completion of the forms. The Member, parent or legal guardian must sign the form in order to be eligible for benefits not covered by IEHP Medicare DualChoice (HMO SNP).
- F. CCS determines program eligibility by evaluating medical necessity and appropriateness of the requested service. All services require prior authorization by CCS. Criteria for eligibility include documentation of a CCS-eligible condition.
- G. Once eligibility is established and the request for service is approved, CCS issues an authorization for treatment and payment to a CCS approved provider (see Attachment 12-4 in Section 12, "Attachments").
- H. PCPs are responsible for continuing all medically necessary health care other than the CCS eligible condition. The IEHP Care Manager follows all CCS referred cases throughout the treatment process and assists with the coordination and continuity of care. CCS is responsible for CM of CCS eligible conditions.
- I. Members not accepted into the CCS Program receive all necessary specialty services through the IEHP and its contracted specialists.
- J. The IEHP Care Manager must assist the PCP in coordinating available services and providing follow-up for Members requiring referral to CCS through the following methods:
 - 1. Provision of telephonic monitoring of Members potentially eligible for the CCS program;
 - 2. Maintenance of continuity of care through coordination with case managers from the CCS programs;
 - 3. Coordination with the PCP to ensure that medically necessary health care services are provided for conditions not eligible for the CCS program; and
 - 4. Maintenance of a continuous and unimpeded flow of medical information between practitioners. The PCP must obtain medical records of health care services provided for CCS-eligible conditions.

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C. Organ Transplant

APPLIES TO:

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

POLICY:

- A. The following major organ transplants are covered by IEHP Medicare DualChoice (HMO SNP).
1. Heart
 2. Liver
 3. Lung
 4. Heart/Lung
 5. Intestine, including multi visceral and combined liver/intestine
 6. Kidney
 7. Pancreas, including kidney/pancreas
- B. Each category of organ transplants may have specific criteria and or exclusions. IEHP shall utilize the Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations to determine Medical Necessity benefit coverage issues to make all utilization decisions.
- C. For IEHP Medicare DualChoice (HMO SNP) Members, IEHP is responsible for the professional and facility components of the rendered transplant services.
- D. Primary Care Physicians (PCPs) and IEHP are required to provide all medically necessary health care services for IEHP Medicare DualChoice (HMO SNP) Members to determine whether a major organ transplant may be indicated, and to refer all adult potential major organ transplant candidates to an approved Medicare Center of Excellence and/or Transplant Center.
- E. PCP and IEHP are responsible for referring all children who are potential organ transplants to the local CCS program and to facilitate submission of requests for transplant to the CCS Central Office (in coordination with the local CCS program).
- F. IEHP is responsible for facilitating all necessary services for potential organ transplants and, once determined to be a candidate providing Care Management support to ensure optimal results.

PROCEDURES:

- A. The PCP or IEHP specialist is responsible for the initial diagnostic work-up prior to a referral to a Medicare designated transplant center. During the initial diagnostic work-up, all prior authorizations for needed procedures or referrals to specialists, second surgical opinions, or hospital admissions must follow IEHP prior authorization referral

12. COORDINATION OF CARE

C. Organ Transplant

procedures.

- B. IEHP is required to follow the procedures listed below for all potential major organ transplant candidates:
1. IEHP will contact the contracted Center of Excellence for the specific organ transplant. The IEHP CM shall coordinate all needed services with the chosen Center of Excellence.
 2. The IEHP Medical Director is responsible for reviewing the selection criteria provided by CMS and directing diagnostic, therapeutic and/or specialty referrals, as indicated.
 3. IEHP Care Manager coordinates all aspects of the referral, including providing all medical information (diagnostic tests, specialty physician notes, etc.) relevant to the particular major organ transplant and selection criteria to the Center. The Care Manager coordinates all referrals and assures that the Member makes all appointments.
 4. If the Member is deemed a suitable candidate by the chosen Center of Excellence, the Center notifies IEHP and the Center submits an authorization request to IEHP for approval.
 5. IEHP Care Manager will coordinate all member needs with the Center of Excellence.
 6. IEHP notifies the Member, by phone within 24 hours, and by letter within three business days.
- C. If a Member is not accepted into a transplant program, the Member's assigned PCP, IEHP, and referral specialists continue to provide all necessary care, including CM services, as needed.

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D. Behavioral Health

1. Behavioral Health Services

APPLIES TO:

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

POLICY:

- A. Primary Care Physicians (PCPs) are required to provide behavioral health and/or substance abuse services, including diagnosis and treatment, within their scope of practice. Substance abuse services are addressed in Policy 12D2, “Alcohol and Drug Treatment Services.”
- B. PCPs treating IEHP Medicare DualChoice (HMO SNP) Members with behavioral health needs beyond their scope of practice, either in terms of diagnosis or treatment, must refer to the IEHP Behavioral Health Program.
- C. Members referred for behavioral health treatment remain enrolled in IEHP and the assigned PCP remains responsible for all necessary physical health care.

PROCEDURES:

Identification/Diagnosis

- A. PCPs are responsible for identifying Members with behavioral health conditions requiring referral to behavioral health specialists for treatment. Identification of these Members can occur during routine physical exams, through review of past medical history or review of systems, or during any visit for acute or chronic conditions.
- B. PCPs are responsible for diagnosing and treating Members’ behavioral health conditions within their scope of practice.
- C. Members presenting with complex or mixed psychiatric symptomatology that makes the diagnosis uncertain must be referred to a behavioral health practitioner, for assessment and diagnosis, through IEHP.

Treatment

- A. PCPs are responsible for treating Members with behavioral health conditions within their scope of practice. Treatment includes the provision of appropriate psychotropic medications, as indicated. Typical behavioral health conditions within the scope of practice of PCPs include:
 - 1. Depression - uncomplicated depression (including post partum events) responsive to first line anti-depressant medication.
 - 2. Anxiety - uncomplicated generalized anxiety requiring the short-term use of anxiolytics.

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D. Behavioral Health

1. Behavioral Health Services

3. Adjustment Reaction - grief reaction, anxiety, or other symptoms as a result of a negative life occurrence. The PCP is responsible for medication management, if necessary.
 4. Attention Deficit Hyperactive Disorder (ADHD) - this disorder should be evaluated by the PCP; however formal diagnosis and medication management of the disorder may or may not be within the PCP's scope of practice.
- B. The following conditions, when combined with significant impairment, are generally beyond the PCP's scope of practice and require a referral to a behavioral health practitioner for evaluation and diagnosis:
1. Schizophrenia;
 2. Schizoaffective Disorder;
 3. Bipolar Disorder;
 4. ADHD - formal diagnosis and/or medical management;
 5. Depression with psychotic or anxiety features, or unresponsive to typical anti-depressant medication;
 6. Obsessive Compulsive Disorder;
 7. Severe Anxiety or Panic Disorder;
 8. Pervasive Development Disorder or Autism;
 9. Anorexia Nervosa (Behavioral component);
 10. Bulimia Nervosa (Behavioral component);
 11. Any Member with symptoms suggestive of mental illness that cannot be definitively diagnosed by the PCP; and
 12. Any Member not responding as expected to prescribed psychotropic medications.

Referral – Emergent

- A. Any IEHP Medicare DualChoice (HMO SNP) Member presenting to a practitioner or facility with an acute behavioral health condition requiring immediate assessment and/or treatment may be referred to the IEHP Behavioral Health Program for referral to the appropriate behavioral health specialty provider for assessment, diagnosis, and treatment as needed by calling (800) 440-4347 during normal business hours, Monday – Friday, 8:00 AM – 5:00 PM. After hours emergency assessments can be referred directly to an IEHP approved psychiatric facility or ER. Approved psychiatric facilities may be located through IEHP's website at www.iehp.org or by calling the Nurse Advice Line at (888) 244-4347.

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D. Behavioral Health

1. Behavioral Health Services

IEHP Behavioral Health Program

Phone – (800) 440-4347

Referral – Non-Emergent

- A. PCPs and/or specialists, with the assistance of the IEHP Care Management (CM) staff as needed, are responsible for referring IEHP Medicare DualChoice (HMO SNP) Members to the IEHP Behavioral Health Program. Referrals may be made online at www.iehp.org by completing the “PCP Referral to Behavioral Health Specialist” form (see Attachment 12-5a in Section 12, “Attachments”).
- B. PCPs must maintain procedures to ensure appropriate records processing to prevent breach of confidentiality. Refer to Policy 7B, “Information Disclosure and Confidentiality of Medical Records” for more information pertaining to the release of medical records.
- C. PCPs may receive assistance coordinating behavioral health care by contacting the IEHP Behavioral Health Program at (800) 440-4347.
- D. Members may self-refer to behavioral health practitioners for treatment by calling IEHP Member Services at (877) 273-4347.

Covered Benefits (See Benefit Manual for specific coverage)

- A. Inpatient services are available, when medically necessary, for the treatment of an acute phase of a behavioral health condition at a participating hospital.
- B. Outpatient services including evaluation, crisis intervention, and treatment are available when medically necessary.

Case Management

- A. The IEHP Behavioral Health CM staff are responsible for managing the coordination of care for Members receiving on-going services with a behavioral health practitioner. Coordination activities include:
 - 1. Facilitating clinician-to-clinician communication between the PCP and the behavioral health practitioner, as necessary;
 - 2. Facilitating transfer of medical records between a treating IEHP physician and the behavioral health practitioner, as necessary;
 - 3. Providing triage and referral for assessment and treatment for Members seeking behavioral health services;
 - 4. Conducting case reviews on open cases and providing authorization for services based on medical necessity criteria; and

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D. Behavioral Health

1. Behavioral Health Services

5. Other CM services, as needed, to assure all appropriate services (home health, laboratory or other diagnostic testing, specialty referral, etc.) are available for the Member.
- B. The IEHP Behavioral Health CM staff are also available for consultation regarding complex cases or to assist with coordinating care with behavioral health practitioners, including County practitioners.
- C. PCPs are responsible for direct coordination of the clinical care of the Member in concert with the behavioral health practitioner through phone calls, transfer of medical records, and IEHP secure internet Behavioral Health Clinical Coordination of Care forms. The “PCP Referral to Behavioral Health Specialist” and “Behavioral Health Initial Evaluation Coordination of Care” forms are intended to assist practitioners in coordinating care (see Attachments 12-5a and 12-5b in Section 12, “Attachments”).

Medications

- A. IEHP covers anti-depressant medications, anxiolytics, hypnotics, anti-bipolar medications, and other psychotropic medications (see the IEHP Medicare Formulary).
- B. IEHP also covers medications, as noted above, for county physicians prescribing for Members. County physicians are also responsible for providing any additional information requested by IEHP.

Reporting

- A. The IEHP Behavioral Health CM staff are responsible for informing PCPs of Members who have significant or complex behavioral health conditions that come to their attention through a behavioral health practitioner. Reporting is done via the IEHP Coordination of Care reports sent to the PCP’s secure website.

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D. Behavioral Health

2. Alcohol and Drug Treatment Services

APPLIES TO:

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

POLICY:

- A. Primary Care Physicians (PCPs) are responsible for identifying IEHP Medicare DualChoice (HMO SNP) Members with active or potential substance abuse problems.
- B. Once Members are identified, PCPs are responsible for providing services for the substance abuse problem within their scope of practice (counseling and/or treatment) and for performing the appropriate medical work-up given the nature of the substance abuse problem.
- C. PCPs are also responsible, with the assistance of IEHP, for referring Members with substance abuse problems to an appropriate treatment practitioner.
- D. Practitioners can directly access consultation and/or services through the IEHP Behavioral Health Program when Members present with substance abuse problems.
- E. Members referred for substance abuse treatment remain enrolled in IEHP and the assigned PCP remains responsible for all necessary physical health care.

PROCEDURE:

Identification/Diagnosis

- A. Medically necessary care for acute medical conditions related to alcohol or substance abuse, such as delirium tremens or gastrointestinal hemorrhage, is provided by the PCP or by specialist referral, if necessary. Members are referred for substance abuse outpatient treatment according to the IEHP Behavioral Health Program.
- B. PCPs are responsible for identifying Members with substance abuse problems. PCPs must include assessment of substance abuse during the initial physical exam performed within 6 months of enrollment. See Policy 10A, “Initial Preventive Physical Exam.” Subsequent contact with the Member provides PCPs the opportunity for evaluation of the Member’s health and questions regarding substance abuse problems.
- C. PCPs should consider substance abuse as a potential issue for Members that present with the following conditions, history, and/or requests:
 - 1. Elevated liver enzymes without evidence of a specific causal factor such as hepatitis, other viral, medication induced, etc.;
 - 2. Repeated skin infections, particularly abscesses or sterile abscesses on the trunk, arms, or legs, with or without needle marks (tracks);

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3. Repeated requests for narcotic pain relievers without physical evidence of genesis of pain;
4. History of endocarditis; or
5. Prior history of substance abuse.

D. Members with substance abuse problems can also be identified in the following ways:

1. IEHP Utilization Management (UM) - identification could occur due to multiple referrals for 'pain control', abnormal liver tests, or Hepatitis B or C sequelae, among others. IEHP UM is then responsible for referring Members to IEHP Care Management (CM).
2. IEHP CM - through active CM and discharge planning of individuals hospitalized for substance abuse sequelae (i.e., endocarditis).
3. Specialists - IEHP specialists seeing Members for conditions listed above, who suspect substance abuse problems, are responsible for informing IEHP CM.
4. IEHP Behavioral Health CM - identification can occur through Member Services referrals, grievances, or through identification by IEHP Pharmacy Staff of Members utilizing large numbers of narcotics and other potentially addictive medications.

Treatment

- A. PCPs are responsible for all necessary health care for Members with substance abuse problems. Depending on the specific substance abuse problem and the health status of the Member, services may include:
1. Limited or comprehensive physical exam with appropriate diagnostic testing to rule out associated medical conditions (e.g., hepatitis, endocarditis);
 2. Limited mental status exam with appropriate treatment or referral for any actual or potential associated psychiatric conditions; or
 3. Referral to specialty practitioners for evaluation as necessary (e.g., cardiology evaluation for valvular defects secondary to endocarditis).

Referral - Emergent

- A. Any IEHP Medicare DualChoice (HMO SNP) Member presenting to a practitioner or facility with an acute substance abuse problem requiring an immediate medical detoxification evaluation may be referred to the IEHP Behavioral Health Program by calling (800) 440-4347 during normal business hours, Monday – Friday, 8:00 AM – 5:00 PM. After hours emergencies can be referred directly to a contracted hospital emergency department for triage and assessment. After hours assistance in locating a contracted hospital emergency department is available by calling the Nurse Advice Line at (888)

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244-4347.

IEHP Behavioral Health Program

Phone – (800) 440-4347

Referral - Non-Emergent

- A. PCPs and/or specialists, with the assistance of the IEHP CM staff as needed, are responsible for referring IEHP Medicare DualChoice (HMO SNP) Members with non-emergent substance abuse conditions to the IEHP Behavioral Health Program. Referrals may be made online at www.iehp.org by completing the “PCP Referral to Behavioral Health Specialist” form (see Attachment 12-5a in Section 12, “Attachments”).
- B. PCPs must maintain procedures to ensure appropriate records processing to prevent breach of confidentiality. Refer to Policy 7B, “Information Disclosure and Confidentiality of Medical Records,” for information pertaining to the release of medical records.
- C. The IEHP Behavioral Health CM staff is responsible for assisting PCPs with referrals using the IEHP supplied list of alternate resources for substance abuse treatment when referral to the designated behavioral health provider does not meet the Member’s needs (see Attachment 12-6 in Section 12, “Attachments”).
- D. PCPs may call the IEHP Behavioral Health Program at (800) 440-4347 for advice or consultation regarding substance abuse issues with Members, including diagnostic or treatment consultation, or the appropriateness of a referral.
- E. Members may self refer for substance abuse services by calling IEHP Member Services at (877) 273-4347.

Covered Benefits

- A. Inpatient services include hospitalization for alcoholism or drug abuse as medically necessary to remove the toxic substances from the system.
- B. Outpatient services include treatment of alcoholism or drug abuse on an outpatient basis, as medically necessary.
- C. Members may self refer to Community Based Organizations (CBOs) for care and assistance on a self-pay basis.

Case Management

- A. IEHP Care Managers assist the PCP with the referral process, follow up with Members referred for alcohol or substance abuse treatment, and facilitate the Member’s transition back into the primary care setting. IEHP Care Managers continue to case manage Members before, during, and after referral and/or treatment.
- B. The IEHP Behavioral Health CM staff are responsible for managing the coordination of

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D. Behavioral Health

2. Alcohol and Drug Treatment Services

care for Members receiving on-going services with a substance abuse practitioner. Coordination activities include:

1. Facilitating clinician-to-clinician communication between the PCP and the substance abuse practitioner, as necessary;
 2. Facilitating transfer of medical records between a treating IEHP physician and the substance abuse practitioner, as necessary;
 3. Providing triage and referral for assessment and treatment for Members seeking alcohol and drug treatment services;
 4. Conducting case reviews on open cases and providing authorization for services based on medical necessity criteria; and
 5. Other CM services, as needed, to assure all appropriate services (home health, laboratory or other diagnostic testing, specialty referral, etc.) are available for the Member.
- C. The IEHP Behavioral Health CM staff are available to assist the PCP, IEHP Care Manager, or both in assessing or managing complex cases.
- D. PCPs are responsible for direct coordination of the clinical care of the Member in concert with the behavioral health practitioner through phone calls, transfer of medical records, and IEHP secure internet Behavioral Health Clinical Coordination of Care forms (see Attachments 12-5a and 12-5b in Section 12, "Attachments"). IEHP will forward the Behavioral Health Clinical Coordination of Care forms to the PCP's secure message center within the IEHP website when received from a behavioral health or substance abuse practitioner, assuming release of information consented to by the Member.
- E. For Members who are identified as having significant substance abuse problems, but refuse treatment referral, IEHP CM is responsible for:
1. Contacting IEHP Behavioral Health CM staff so that a joint CM plan can be developed.
 2. Documenting, with input from the PCP, continued refusal to accept referrals for treatment.
 3. Documenting the impact the refusal has on the medical status of the Member and evidence of non-compliance with other aspects of medical care.

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E. Chiropractic Care

APPLIES TO:

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

POLICY:

- A. Chiropractic services to correct subluxation of the spine are covered when provided by a qualified chiropractor.
- B. Prior authorization is required from IEHP for chiropractic services.
- C. Members that are referred to such services by their Primary Care Physician (PCP) as part of a care plan must be case managed by IEHP to assure the coordination of care for the Member.
- D. Members that request assistance from their PCP to receive such services must be referred to IEHP Member Services, (877) 273-4347, for assistance and prior authorization.

PROCEDURE:

- A. PCPs are responsible for identifying Members with head or neck pain, who would benefit from chiropractic care.
- B. PCPs may contact IEHP Member Services at (800) 440-4347 for assistance in referring a Member to chiropractic services.
- C. PCPs are responsible for facilitating transfer of pertinent medical information to the chiropractor, if necessary for the health care of the Member.
- D. Members can self-refer to chiropractic services without assistance or referral from the PCP by calling IEHP Member Services at (877) 273-4347.
- E. Additional benefits may be available through Medi-Cal.

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F. Developmental Disabilities

APPLIES TO:

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

POLICY

- A. Members identified with or suspected of having developmental disabilities receive all medically necessary and appropriate developmental screening, primary preventive services and diagnostic and treatment services.
- B. For Members at risk of parenting a child with a developmental disability, IEHP provides genetic counseling and other covered prenatal genetic testing services when medically indicated.
- C. IEHP Care Management (CM) coordinates services with the Inland Regional Center (IRC) to achieve optimum outcomes for Members with developmental disabilities.

PROCEDURE

Primary Care and Specialty Referrals

- A. Primary Care Physicians (PCPs) are required to provide all necessary primary care for individuals with developmental disabilities including:
1. Well Child Exams;
 2. Immunizations;
 3. Developmental status screening (e.g., use of Denver Development Screening tool) (see Attachment 12-7 in Section 12, “Attachments”);
 4. Illness or Injury Care;
 5. Diagnostic testing (laboratory, x-rays) as needed;
 6. Health Education as needed; and
 7. Other primary care services as needed.
- B. PCPs are required to arrange for and/or request from IEHP all medically necessary specialty practitioner, diagnostic or therapeutic services including:
1. Referral to specialist or sub-specialist practitioners (e.g., neurologists, psychiatrists);
 2. Referrals for occupational or physical therapy;
 3. Orders for medically necessary durable medical equipment (DME) or home health services; and

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4. Referrals for specialized diagnostic testing (e.g., CT or MRI).
- C. PCPs, with assistance from IEHP CM, are responsible for assessing the behavioral health status of Members and referring those Members with behavioral health disorders outside their scope of practice to IEHP Behavioral Health Program. Refer to Policy 12D1, “Behavioral Health Services” for more information.
- D. IEHP Utilization Management (UM)/CM staff will assist PCPs in arranging for all necessary specialty care for Members, including out-of-network referrals, if a service is not available in-network, as needed due to the condition of the Member.
- E. PCPs or OB practitioners who identify the need for prenatal genetic diagnostic testing are required to refer Members to a state approved Prenatal Diagnosis Center (see Attachment 10-2 in Section 10, “Attachments”).
- F. PCPs are responsible for referring Members to IRC when they need non-medical, home and community based services such as:
1. Training in skills for daily living;
 2. Acquisition of skills and behavior and/or;
 3. Family support;
 4. Day habilitation;
 5. Respite care; and/or
 6. Residential care or assisted living.
- G. PCPs are responsible for referrals of children (over 36 months of age) and adults suspected of having developmental disabilities to IRC when requested by the Member, or his/her family if a minor. The Member’s disability must originate before the 18th birthday, be expected to continue indefinitely, and constitute a substantial disability. A list of definitions and eligibility criteria can be found in the California Code of Regulations (CCR) Title 22 Sections 54000, 54001, 54002 and 54010. The IRC reviews referrals to determine IRC eligibility and considers the need for developmental programs or family support services that are not available from other resources.
- H. Referrals to IRC from IEHP should be directed to the IRC’s intake coordinator and include the following information:
1. The reason for referral;
 2. The complete medical history and physical examination, including appropriate developmental screens;
 3. The results of developmental assessment/psychological evaluation and other diagnostic tests as indicated; and
 4. The referral should be directed to:

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F. Developmental Disabilities

Inland Regional Center
1365 S. Waterman
San Bernardino, CA 92408
(909) 890-3000

* IRC Medical Consultants are available for consultations on appropriate medical tests necessary for obtaining a specific diagnosis.

- I. Intake staff reviews the referral to the IRC within 15 working days of receipt. Evaluations must be performed within 60 days following review of referral, or sooner if a delay in assessment would expose the Member to unnecessary risk to health and safety. IRC notifies IEHP and the Member within 120 days after the referral is made regarding the Member's eligibility and recommendations for services.

Case Management

- A. IEHP CM is responsible for performing the following activities:
1. Assisting the PCP with the referral to IRC including arranging for transfer of medical information, approving medically necessary referrals and contact with IRC;
 2. Consulting with the PCP in the development of the individual care plan (ICP) for the Member; and
 3. Coordinating necessary follow-up between the PCP, specialty practitioners and IRC to assure an organized care plan and delivery for the Member.
- B. IEHP CM remains responsible for providing care coordination and CM services for Members regardless of whether or not they receive services from IRC.
- C. IEHP is responsible for providing assistance to the PCP and IRC in complex or difficult cases or when differences arise regarding necessary services or care plans.

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G. Vision Services

APPLIES TO:

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

POLICY

- A. Vision services, including comprehensive eye exam, lenses and frames for Medicare DualChoice (HMO SNP) Members are provided directly by IEHP.
- B. All routine vision benefits require prior authorization.

PROCEDURE

Primary Care and Specialty Referrals

- A. PCPs are expected to schedule and provide one initial preventive physical exam within 12 months of enrollment for all DualChoice Members. A component of the initial preventive physical exam requires vision screening of the eyes to determine the presence of eye disease or potential refractive errors. The PCP must advise the Member of findings and encourage the Member to seek vision services when appropriate. Refer to Policy 10A, "Initial Preventive Physical Exam."

Follow-up Vision Screening

- A. The PCP must continue to observe Members for vision conditions and advise Members to seek vision services as applicable.

Referral

- A. PCPs are responsible for referring Members to an IEHP Vision Provider if non-medical vision conditions are noted during the visits or if the Member has Diabetes and is being referred for a Diabetic Retinal Exam (DRE).

Vision Providers for Medicare DualChoice (HMO SNP) Members

- A. A Vision Provider list is included in the IEHP Provider Directory. To receive assistance with a referral to a Vision Provider call the IEHP Provider Relations Team at (909) 890-2054. To obtain assistance PCPs may contact IEHP Member Services at (800) 440-4347 and Members may call 1-877-273-4347.

Vision Benefits for Medicare DualChoice (HMO SNP) Members

- A. Members are limited to one bilateral comprehensive eye examination with refraction including dilation when medically indicated in a 24-month period unless more frequent examinations are determined to be medically necessary.
 - 1. All routine vision benefits require prior authorizations.

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2. Providers are strongly encouraged to obtain authorizations through **Interactive Voice Response (IVR) line at (888) 355-2234** or through the Provider Relations Team at (909) 890-2054. Providers must have their five digit IEHP ID Number (PIN) available to obtain authorizations. Authorizations are good only for the month in which they are issued since individual eligibility for Members is determined on a month-to-month basis. Consequently, all authorizations expire at the end of the month.
 3. Before ordering services Providers must verify eligibility through IEHP's Online Eligibility Verification System at www.iehp.org. When ordering medically necessary absorptive lenses, medical justification must be provided. IEHP designated contract optical lab order forms are available online at www.iehp.org.
 4. Eyeglass frames are covered up to \$100 every two years. Eyeglass frames provided to Members must be of good quality with the manufacturer's or American distributor's name or identification clearly stamped on the frame. Only frames that Providers supply to the general public may be given to Members.
 5. The maximum allowance for contact lenses is \$150 every two years in lieu of lenses and frames.
 6. Replacement frames and lenses are not a covered benefit through the VER process for DualChoice Members.
 7. Members must sign a Non-Covered Service/Materials Waiver Form (see attachment 12-11a and 12-11b in Section 12, "Attachments") for expenses exceeding the covered material benefit.
- B. Providers must use the following IEHP designated contract optical lab when ordering lens materials. IEHP Providers must use the IEHP Lab Order Form (see attachment 12-8 in Section 12, "Attachments") when ordering materials from the IEHP designated contract lab.
- Express Lens Lab
17150 Newhope St., Suite 305
Fountain Valley, CA 92708-4251
(714) 545-1024
(714) 556-2026 Fax
- C. Members diagnosed with diabetes are entitled to an annual Diabetic Retinal Examination (DRE). Vision Providers are required to coordinate care with the Member's PCP by notifying the PCP in writing of the results of the DRE.
1. Prior to rendering services, Provider is required to obtain an authorization by contacting IEHP at (909) 890-2054.

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2. For the purpose of benefit availability, annual shall mean once per calendar year but no less than nine months since the last DRE.
 3. DRE may be performed on the same day as a comprehensive examination if the Member is eligible for the periodic routine eye examination.
 4. Vision Providers are required to coordinate care with the Member's PCP by notifying the Member's PCP in writing of the results of the DRE, utilizing the IEHP PCP Vision Report Form (see Attachment 12-9 in Section 12, "Attachments").
- D. The IEHP Therapeutic Pharmaceutical Agents (TPA) Program allows IEHP credentialed and TPA certified providers to perform specific services to Members without a referral from the Members' PCPs.
1. Any IEHP Vision Provider may provide TPA services to Members if the following minimum criteria are met:
 - a. Provider is credentialed by IEHP.
 - b. Provider must be TPA certified as verified by the California Board of Optometry.
 - c. Provider must be contracted by IEHP to provide those services.
 - d. Symptoms and conditions covered under the Program are consistent with Section 3041 of the Business and Professions Code and Section 1569 of the California Code of Regulations.
 - e. All Members with confirmed chronic conditions must be referred to their PCP.
 2. Additional equipment that is required in order to provide TPA services includes:
 - a. Binocular Indirect Ophthalmoscope
 - b. Condensing Lens.
 - c. Automated Threshold Field Analyzer
 - d. Goldman Applanation Tonometer
 3. TPA Providers are required to notify the Member's PCP that medical services have been provided within two working days of rendering services. Providers must complete the PCP Vision Report form (see Attachment 12-9 in Section 12, "Attachments") and distribute legible copies as follows:
 - a. 1st Copy Attach to Claim Form when submitting for reimbursement.
 - b. 2nd Copy Mail or Fax to PCP.
 - c. 3rd Copy Attach to Vision Provider file.

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3. The PCP Vision Report form must be completed in its entirety and include:
 - a. Patient's presenting symptoms
 - b. Diagnosis description
 - c. ICD-9 diagnosis code(s)
 - d. Procedure(s) and/or treatment performed
 - e. If applicable, the name and type (form) of medication prescribed
 - f. Provider's signature
 - g. Date of the next follow-up appointment, if indicated, in "Next Visit" otherwise specify N/A (not applicable)
4. Claims for TPA services must be submitted on a CMS 1500 Health Insurance Claim Form and include all information necessary to process the claim for payment. The completed, signed and dated PCP Vision Report Form must be attached to the claim in order to be considered for reimbursement.
 - a. Under the TPA Program, IEHP performs retrospective review on all non-authorized services. Claims are also reviewed for unbundling and inappropriate use of codes. Claims with unbundled services, or where two or more lower level codes are billed on the same date of service without substantiated documentation, result in lower reimbursement.
 - b. Members cannot be billed for any covered service, including services that have been denied as a result of improper billing.
5. Prescription Medications
 - a. All prescription medications prescribed to IEHP Members must comply to IEHP's formulary. Providers wishing to prescribe non-formulary medication must first submit a Pharmacy Exception Request (PER) for approval
 - b. TPA Providers must use PER forms for the following:
 - 1) Medication or dosage not included in the IEHP formulary.
 - 2) Code 1 medications used for treatment of conditions or criteria other than those specified by their restrictions.
 - 3) Branded medications when generic is available.
 - 4) Prescriptions for formulary medications that do not comply with Dose/Duration/or Quantity guidelines (as outlined in the IEHP formulary).

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- c. A Member currently taking medication that has been deleted from IEHP's formulary may continue to receive the medication, if prescribed.
 - d. IEHP reviews individual medication requests and either approves, modifies, or denies the PER within one working day.
- E. IEHP PCPs continue to provide all necessary health care services to Members even if the Member has been referred to a Vision Provider for services.

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1. Vision Exception Request

APPLIES TO:

- A. This policy applies to Medicare DualChoice (HMO SNP) Members only.

POLICY:

- A. All non-routine benefits require prior authorization utilizing the Vision Exception Request (VER) form.
- B. All VERs must contain information that supports the medical necessity of a non-routine benefit.
- C. All requests are reviewed and acted on within three working days.

PROCEDURE:

- A. IEHP supplies all Vision Providers with Vision Exception Request (VER) forms are available online at www.iehp.org.
- B. VER forms are used for the following:
1. Second eye examination within 24 months- covered when signs or symptoms indicate a need and documentation substantiates the need for a second exam.
 2. Single Vision Lenses in lieu of Bifocals- Two pairs of single vision glasses, one for near vision and one for distance vision are covered when one of the following exists:
 - a. Sufficient evidence that a Member cannot wear bifocal lenses.
 - b. Member is currently using two pairs of glasses.
 - c. New presbyopes must have failed with bifocals first.
 3. Other Covered Items- VER Required
 - a. Ptosis crutches, occluders, bandage contact lenses, prosthetic eyes and prosthetic scleral shells are covered when medically indicated. A brief justification must be provided when prescribing or dispensing the covered item.
- C. IEHP reviews and responds to all VERs within three working days. IEHP reviews the VER, verifies eligibility, benefit availability and previous utilization and either approves, modifies, defers, or denies the request as follows:
1. Approved - A VER Response Form is faxed back to the Provider with an authorization for the requested services.

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1. Vision Exception Request

2. Modified - A VER Response Form is faxed back to the Provider with an authorization that describes the modified services/and or materials authorized.
3. Deferred - A VER that has been deferred is one that has been placed on **“hold”** pending additional information.
 - a. A VER Response form is faxed back to the Provider requesting the required information when the information on the original VER is incomplete or insufficient.
 - b. If the requested information is not received within 3 days of the initial request a second notice is sent. If the Provider does not respond within 3 days of the second notice, the VER is denied.
 - c. Once the requested information is received, the VER is reviewed and a decision is made within 3 working days of receipt of the required information.
4. Denied - A VER Response form is faxed back to the Provider with the denial reason.

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G. Vision Services

2. Vision Provider Referral

APPLIES TO:

- A. This policy applies to IEHP Medicare DualChoice (HMO SNP) Members only.

POLICY:

- A. IEHP Vision Providers are required to provide evaluation and management services within their scope of practice to Members with known or suspected diseases and conditions of the eye and visual system.
- B. Vision Providers caring for Medicare DualChoice (HMO SNP) Members that require further diagnosis and treatment beyond the scope of practice of the Vision Provider must refer the Member to the appropriate health care provider, as follows:
1. Medicare DualChoice (HMO SNP) Members with a known or suspected pathology of the eye, or any of its appendages, may be referred directly by the Vision Provider to an Ophthalmologist by submitting a referral request to IEHP.
 2. Medicare DualChoice (HMO SNP) Members with a known or suspected medical condition that may be systemic or neurological in nature shall be referred back to the Member's Primary Care Physician (PCP) for appropriate coordination of care.

PROCEDURES:

Identification/Diagnosis

- A. Vision Providers are responsible for identifying Members with any pathological ocular health condition that requires treatment. Identification of these Members can occur during the routine physical examination of the eyes and visual system and through review of the past medical history or review of systems, or during any visit for acute or chronic conditions.
- B. Vision Providers are responsible for diagnosing and treating Members' pathological ocular health conditions that are within their scope of practice.
- C. Members presenting with complex or mixed symptoms or conditions that make the diagnosis uncertain or that may indicate a systemic etiology must be referred to the Member's PCP for assessment, diagnosis, and/or treatment. If the Vision Provider determines that an ophthalmologist consultation and/or treatment is warranted, the Vision Provider can submit a referral directly to IEHP.
- D. Vision Providers are responsible for treating Members with ocular conditions within their scope of practice. Treatment includes the provision of appropriate optical devices and the use of topical ophthalmic pharmaceutical agents, as indicated. Typical ocular health

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2. Vision Provider Referral

conditions within the scope of practice of Vision Providers, depending on their level of certification and legal authority include, but are not limited to:

1. Refractive and motility disorders of the human eyes.
 2. Ocular infections.
 3. Ocular inflammations and allergies.
 4. Ocular trauma and superficial foreign bodies.
 5. Primary open angle glaucoma.
 6. Nothing in this section shall be construed to grant privileges to the optometric Vision Provider beyond the scope set forth in the statutes and regulations of the Optometry Code [B&P Section 3041 and CCR Section 1569].
- E. Scope and limitations to IEHP Medicare DualChoice (HMO SNP) Vision Benefit: IEHP Medicare DualChoice (HMO SNP) Members are entitled to a routine comprehensive eye examination every twenty four (24) months and, if medically indicated, a pair of lenses every 24 months. Eyeglass frames are covered up to \$100 every 24 months. Contact Lenses are covered up to \$150 every 24 months in lieu of frames and lenses. When indicated, medical evaluation and management services of certain eye conditions are available to the Member through an IEHP Vision Provider. Treatment of any eye condition shall be limited to acute conditions. The long-term treatment of chronic medical conditions of the eyes shall be managed and coordinated by the Member's PCP.

Referral to PCP

- A. Vision Providers shall complete a PCP Vision Report (see Attachment 12-9 in Section 12, "Attachments") to report examination findings and/or treatment provided during a active ocular condition that require further evaluation or follow up by Member's PCP.
1. To ensure Members continuity of care, Vision Providers are required to notify the Member's PCP if medical services have been provided within two days of rendering service.

Referral to Ophthalmologist

- A. Vision Providers, with the assistance of IEHP Utilization Management (UM) staff, are responsible for referring Medicare DualChoice (HMO SNP) Members to the appropriate ophthalmologist specialty provider for assessment, diagnosis and treatment as needed.
- B. Vision Providers shall prepare a written request for referral on the standardized Ophthalmologist Referral Request Form (see Attachment 12-10, in Section 12 "Attachments") and submit the completed referral to IEHP within 24 hours of the

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2. Vision Provider Referral

encounter with the Member. Vision Providers may indicate desired ophthalmological sub-specialty by selecting: General Ophthalmology or Retinal Specialist.

- C. IEHP UM staff, are responsible for faxing back a copy of the completed referral form including the specific ophthalmologist selected back to the Vision Provider.
- D. Vision Providers may also call the IEHP Provider Relations Team and/or Associate Medical Director for advice or consultation regarding Member ocular health issues, including diagnostic or treatment consultation, or the appropriateness of a referral.

Case Management

- A. IEHP CM is responsible for managing the coordination of care for Members receiving on-going services with a specialist of any type. Coordination activities include:
 - 1. Facilitating clinician-to-clinician conversations between the PCP and the Vision Provider as necessary.
 - 2. Facilitating transfer of medical records between a treating IEHP Vision Provider and the PCP and/or the ophthalmic specialty provider as necessary.
 - 3. Other CM services as needed to assure all appropriate services (laboratory or other diagnostic testing, specialty referral, etc.) are available for the Member.
 - 4. Informing PCPs when information is received directly by IEHP CM that a Member has accessed out-of-network ophthalmologist health services without going through the PCP. IEHP CM staff is responsible for arranging the transfer of clinical information, including medical records (assuming release of information consented to by the Member) to the PCP. Refer to Policy 7B, "Information Disclosure and Confidentiality of Medical Records" for information regarding the release of medical records.
- B. PCPs are responsible for direct coordination of the clinical care of the Member in concert with the ophthalmologist specialty provider through phone calls, transfer of medical records, and other specialty referrals as indicated.

Medications

- A. IEHP covers medically necessary medications for the treatment of ocular disease as listed in the IEHP formulary.

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H. Health Management Program

APPLIES TO:

- A. This policy applies to all IEHP Medicare Dual Choice (HMO SNP) Members

POLICY:

- A. The IEHP Health Management (HM) Program is designed to identify Members with specific chronic diseases that are relevant to IEHP's membership or other conditions and facilitate access to providers, health education activities, and other specific services to improve Member health outcomes.
- B. Through data collection and analysis, IEHP identifies and selects at least two chronic conditions for its HM Program.
- C. The HM Program coordinates with the Member's Primary Care Physician (PCP) or other treating practitioner to coordinate care with emphasis on the prevention of exacerbation and complications of the medical condition.
- D. The IEHP HM Program is based on evidence-based clinical practice guidelines.
- E. Members have the right to refuse participation or opt out of HM Programs.

PROCEDURES:

Program Overview

- A. The HM program is designed to support and serve as a resource to both Members and practitioners by:
 - 1. Assisting in the Management of Members with identified high-risk factors by providing education, assessment, and other services as necessary;
 - 2. Enhancing Members' ability to self-monitor and report potential changes in their medical condition;
 - 3. Utilizing the initial health risk assessment (HRA) or the disease specific survey (Asthma, Diabetes, or High Risk OB) to assess multiple areas including medical, behavioral, psychosocial, depression, socio-economic, cognitive, lifestyle, and functional needs of the targeted population;
 - 4. Using the results of the HRA and the disease specific surveys as a foundation to develop an individualized care plan and refer to the appropriate health care professionals or practitioners to provide care. Completed care plans are sent to the practitioners via fax and are posted on the provider web portal and Members may receive a copy upon request;
 - 5. Using completed care plans to communicate Members' health status with practitioners and to educate Members on nutrition, healthy lifestyle, risk factors,

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H. Health Management Program

- signs and symptoms of the medical conditions, the importance to adherence medical treatments and medications;
 6. With Member's consent, providing information about the Member's condition to Member's caregivers, legal guardianship, or conservatorship;
 7. Evaluating Members who are referred to the HM program from internal and external resources or agencies, (e.g. hospital, home health agency, or In-Patient Review Nurses);
 8. Promoting optimal patient/physician interactions and encourage Members to communicate with their practitioners about their health condition and medical treatment;
 9. Providing feedback to enhance care management and improve Members' understanding of their medical condition or health maintenance;
 10. Encouraging adherence to practitioner treatment plans including medication use, obtaining preventive services, attending Health Education Classes, lifestyle modifications and referrals to external agencies and resources; and
 11. Determining the level of interventions based on Members' health risk factors. Levels of interventions range from annual mailing of educational materials to in-depth telephonic interactions as frequently as needed.
- B. IEHP uses electronic health records and maxMC, a medical management system, to store and integrate Members' information from various systems to facilitate access to Member health information for continuity of care, i.e. utilization management data, care management, disease program line, nurse advice line, wellness programs, and other relevant clinical information.
- C. IEHP performs quality improvement activities including measuring the effectiveness of disease specific program, monitoring and measuring active Member participation rates at least annually.
- D. Currently, there are three HM Programs: Asthma, Diabetes and High Risk Obstetric (HROB) (see Attachments 12-12, 12-13 and 12-14 in Section 12, "Attachments").

Member Identification and Risk Stratification

- A. Eligible Members are identified for one of the HM Programs through the use of laboratory results, pharmacy, claims or encounter data, Utilization Management (UM) and Care Management (CM) processes, health risk assessment survey results, information from electronic health records, data from health management, wellness program or Nurse Advice Line, or other administrative data sources, as well as Member, Provider and client organization referrals. Eligible Members are systematically identified within 30 days of receiving new or updated information from data source.
- B. Members are then assessed for risk factors and stratified into risk levels based on utilization of medication, hospitalization, practitioner, and ED encounters.

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H. Health Management Program

- C. Program participation is defined by a passive methodology. All eligible Members are initially contacted by distributing the welcome packet via U.S. mail and offered services and given the opportunity to actively opt out. Members who do not actively opt out remain in the program.
- D. Wellness Coordinators and Care Managers staff each HM Program and initiate interactions with Members and practitioners.
- E. Members are reassessed for risk factors and re-stratified on a monthly basis. New information from encounter and pharmacy data, referrals, after-hours Member calls and other patient contact information is added to the HM database daily and serves as concurrent re-stratification opportunities. The re-stratification criteria are based on identification of additional risk factors.

HM Program Interventions by Stratification

- A. Eligible Members receive the following written information about the HM program, including the frequency of the interventions which are based on the identified risk level and the results of the disease specifics:
 - 1. **Level I** – All Level I Asthma and Diabetic Members receive an initial letter and program brochure that includes information about the specific HM Program in which they are enrolled. Thereafter, an annual letter is mailed to remind Members of the services available to them. All Level 1 pregnant Members over the age of 18 years receive the initial mailings, along with an assessment survey. Pregnant Members 18 years of age and younger **do not** receive any written communications until and unless a telephone conversation with the HROB Care Manager determines that mailings are appropriate. At least one follow-up telephone call is made to the HROB Member within one month of the assessment survey, then one call within 90 days of initial contact and then every trimester until eight weeks post partum.
 - 2. **Level II** – All Level II Members receive an initial letter and program brochure that includes information about the specific HM program(s) in which they are enrolled. All Level II Asthmatic and Diabetic Members receive a mailed or telephonic assessment to gather additional information about clinical and functional status. The Care Manager reviews the assessment information and develops an Individualized Care Plan (ICP) specific to the Member's needs. All Level II asthmatic and diabetic Members receive at least one follow-up telephone call within two months of the assessment survey and then every six months, or as appropriate to the Member's clinical condition. Level II HROB Members are contacted within one month of the intake assessment and then every two months until eight weeks post partum.
 - 3. **Level III** – All Level III Members receive the Level II interventions plus additional telephonic monitoring as appropriate to their condition. Level III Members in the Asthma or Diabetes HM Programs receive an in-depth telephonic intake assessment. All Level III Asthmatic and Diabetic Members are contacted

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H. Health Management Program

at least once every three months or more frequently if needed. All Level III HROB Program Members receive a mailed intake and/or an in-depth telephonic intake assessment. Level III HROB Program Members are contacted at least every 45 days until 8 weeks post partum. Home visits may also be conducted, depending on the need, to better assess the home environment for all programs.

4. Health Management Members that require a higher level of care are transitioned from Health Management to Care Management. Examples of cases that would be transitioned to the Care Management unit are: CHF, COPD, transplant candidates, history of non-compliance, and postpartum Members requiring continued follow-up.

- B. **Individual Care Plans** – Individual Care Plans are developed for all Asthmatic, Diabetic, and HROB Members who have been identified with a risk Level of II or III that have completed an assessment survey. Development of a Member’s ICP is based on data provided from the practitioner, written or telephonic assessment, ongoing monitoring activities, and discussion with the Member and/or family members as appropriate. Copies of the ICP are sent to the Provider as feedback to the practitioner regarding their patient. A care plan summary is available to the Member as well upon request. They are updated as the Member’s condition or needs change.

Access to Program Services

- A. Members are provided with the toll free Health Management phone number (1-866-224-4347) once they are identified for the HM Asthma, Diabetes or HROB Program. If the Member is experiencing a life-threatening emergency, they are instructed to hang up and immediately dial 911. Members can reach a Care Manager or a Wellness Coordinator from Monday through Friday, between the hours of 8 AM and 5 PM. Care Manager educates Members about the disease management program to include but not be limited to the following areas;
1. Signs and symptoms of the medical condition
 2. Medication
 3. Lifestyle
 4. Preventive health guidelines
 5. Utilization Management Process
 6. Case Management Process
 7. Relevant medical test results, if applicable
 8. Wellness Programs
 - a. Sweet Success
 - b. Smoking Cessation
 - c. Weight Loss Program

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- d. Community Resources or Agencies
- B. All incoming calls to HM Staff must come from the toll free Health Management phone number. Members are not provided with the HM Staff's direct phone numbers. In addition, HM Staff's phone numbers are blocked and any Member with the Caller ID function is unable to obtain the HM Staff's phone number. Members are not able to reach HM Staff's voice mail.
- C. If a call is received after normal business hours, an IEHP recorded message informs the Member that the After Hours Nurse Advice Line is available to assist them. If the Member is experiencing a life-threatening emergency, they are instructed to hang up and immediately dial 911. The Member can request to be connected directly to the After Hours Nurse Advice Line directly with the toll free number provided in the recorded message.
- D. Practitioner Access to HM Program Staff:
 - 1. Practitioners can call (866) 224-4347 to speak with specific HM Program Staff during regular hours of operation Monday to Friday, 8 – 5pm.
- E. Members and Practitioners can access HM Program services through visiting the IEHP website at www.iehp.org.

External HM Program Referrals

- A. Members are identified through numerous sources such as IPAs, Practitioners, Providers, hospital staff and Community Based Organizations.
- B. PCPs and OBs are responsible for referring Members for necessary Health Management services. PCPs, OBs, IPAs may refer Members by calling IEHP's Health Management Unit at (866) 224-4347. Referral to IEHP's Health Management unit for Members diagnosed with:
 - 1. Asthma
 - 2. Diabetes
 - 3. High Risk Pregnancy
- C. The Health Management referrals to the above mentioned programs are reviewed and triaged by a Licensed Nurse.
- D. Appropriate interventions are performed depending upon the assigned risk level of the Member.
- E. Based on the Member's responses to the Intake Assessment and/or Health Risk Assessment surveys, the Health Management staff developed individual care plans and shared with the Practitioners.

Practitioner Communications

- A. Practitioners receive a list of Members participating in the HM Program and their current risk every quarter.

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- B. Practitioners are sent faxes and/or letters regarding their individual Members participating in the Program following the initial assessment process. The communication contains information about the Member's assigned risk level and when to expect future communications.
- C. Practitioners receive ongoing communications via fax or phone with information regarding an individual Member's status or potential patient safety issues subsequent to staff discussions/interactions with the Member or Member encounters.
- D. Urgent information is communicated to practitioners via phone calls appropriate to the clinical urgency of the situation within 24 hours of the event.

Feedback

- A. IEHP gathers information annually from practitioners regarding the usefulness of services available through the HM Program, the usefulness of decision support materials, and the helpfulness of the staff providing services.
- B. IEHP gathers information annually from Members through a Member Satisfaction Survey. Information is also collected through grievance/complaints and appeal data related to the Program. All of the data is analyzed annually to identify opportunities to improve program content, operations and effectiveness.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Effective date:	January 1, 2011
Chief Title: Chief Medical Officer	Revised date:	January 1, 2012

12. COORDINATION OF CARE

Attachments

<u>ATTACHMENT</u>	<u>DESCRIPTION</u>	<u>POLICY CROSS REFERENCE</u>
12-1	Standards of Practice for Case Management	12A1
12-2	Overview of CCS Medical Eligibility	12B
12-3	CCS Program Referral Forms	
	a. SAR and CCS Referral Form – New Case	12B
	b. SAR and CCS Referral Form – Established Case	12B
12-4	Directory of Local CCS Approved Hospitals	12B
12-5	IEHP Behavioral Health Clinical Coordination of Care Forms	
	a. PCP Referral to Behavioral Health Specialist	12D1, 12D2
	b. BH Initial Evaluation Coordination of Care Report	12D1, 12D2
12-6	Substance Abuse Resources	12D2
12-7	Denver Development Screening Tool	12F
12-8	IEHP Lab Order Form	12G
12-9	IEHP PCP Vision Report Form	12G
12-10	Ophthalmologist Referral Form	12G2
12-11a	Non-Covered Services/Materials Waiver Form	12G
12-11b	Non-Covered Services/Materials Waiver Form	12G
12-12	Asthma Health Management Program	12H
12-13	Diabetes Health Management Program	12H
12-14	High Risk Obstetric Program	12H



Standards of Practice for Case Management



The Evolution of the Standards

The Definition of Case Management

Philosophy and Guiding Principles

Case Management Practice Settings

Components of the Process

Standards of Case Management

Acknowledgements and Glossary

Standards of Practice for Case Management, Revised 2010[©]

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CASE MANAGEMENT SOCIETY
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Standards of Practice
for Case Management,
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Foreword

It is our pleasure to present the 2010 revision of the Case Management Society of America's (CMSA) *Standards of Practice for Case Management (SoP)*. These Standards were first published in 1995 and revised in 2002. Today, as our nation faces ever-changing challenges to our health care system, CMSA recognized the need to revise the *Standards of Practice* to be more reflective of the rapidly growing and expanding role of case managers and the increased awareness of case managers as crucial members of the health care team. These key issues, among others, provided the impetus to re-examine and redefine our role in the current health care matrix.

As our profile becomes ever more visible, it is critical that we examine ourselves and set standards by which we must be held accountable. Among the many changes to this edition, one of special note is the revised qualifications language. To establish our position as providers of service and to improve our position for reimbursement of case management services, it is imperative to establish accepted qualifications for case managers. Equally important, it is essential to validate our positive outcomes as we work with patients through case management interventions. Ultimately, by clarifying our qualifications and validating outcomes achieved, the *Standards of Practice* will strengthen the case management professional.

This edition of the *Standards of Practice* is the product of many hours of labor, research, and deliberation among those who served on the task force, reference committees, case managers at-large, and the CMSA Board of Directors, who ultimately approves the *Standards of Practice*. There are many people to thank for their role in this revision. First, we must acknowledge Peter Moran who had the wisdom to call for the revision during his presidency and the foresight to ask Carrie Marion to lead the task force. We would also like to recognize the efforts of Cheri Lattimer and Danielle Marshall who have shepherded and supported the project over the past two years.

Lastly, we would like to thank you, the case managers, for providing service to those in need, and for being part of "what is right" in health care through your passion and commitment.

The time from conception to fruition of this edition of our *Standards of Practice* has spanned three CMSA presidencies, and we are grateful to have been part of this historic moment-in-time for case managers and CMSA.

Jeff Frater, RN, BSN, CMSA President (2008 – 2009)

Margaret "Peggy" Leonard, MS, RN-BC, FNP, CMSA President (2009 – 2010)

Preface

The *Standards of Practice for Case Management* were first introduced by the CMSA in 1995 and then revised in 2002. We are pleased to offer the *Standards of Practice for Case Management*, 2010 revision, which provides voluntary practice guidelines for the case management industry. The *Standards of Practice* are intended to identify and address important foundational knowledge and skills of the case manager within a spectrum of case management practice settings and specialties.

The 2010 Standards reflect many changes in the industry, which resonate with current practice today. Some of these changes include the following:

Minimizing fragmentation in the health care system, using evidence-based guidelines in practice, navigating transitions of care, incorporating adherence guidelines and other standardized practice tools, expanding the interdisciplinary team in planning care for individuals, and improving patient safety.

We believe that these are all important factors that case managers need to address in their practices. The 2010 *Standards of Practice* contain information about case management practice, including definition, practice settings, roles, functions, activities, case management process, philosophy and guiding principles, as well as the standards and how they are demonstrated. This document is intended for voluntary use and is not intended to replace relevant legal or professional practice requirements.

The 2010 *Standards of Practice* were developed through the efforts of dedicated case managers who spent countless hours synthesizing information over two public comment periods to develop this document.

The teams include:

- (1) A core task force made up of representatives of the case management field in various practice settings and disciplines
- (2) A larger reference group that included the CMSA leadership and Board of Directors, legal advisors, and the case management industry
- (3) Other case management experts in the industry
- (4) Case managers at-large during the Public Comment period

It has been my pleasure to work on this project with the talented and committed individuals who are raising the bar of excellence in the field of case management.

Carrie Marion, RN, BSN, CCM
Committee Chair

I. Introduction

The consistent delivery of quality health care services and the high financial cost generally associated with those services are important concerns that touch everyone, from our leaders in Washington, D.C. to the American public. *Payers* continue to seek methods for reducing costs while advancing quality and transparency. *Providers* explore methods to define and report quality while maximizing reimbursement. Too frequently, the health care *consumer* is left to navigate the health care system without the tools, resources, support or education that are vital to this role.

Although a number of strategies for health care reform have been espoused and debated, case management has emerged as an important intervention that fosters the careful shepherding of health care dollars while maintaining a primary and consistent focus on quality of care and client self-determination.

Founded in 1990, the CMSA is the leading non-profit association dedicated to the support and development of case management. The strategic *Vision* of CMSA approved in 2009 is as follows:

Case managers are recognized experts and vital participants in the care coordination team who empower people to understand and access quality, efficient health care.

To complement this *Vision*, case management practitioners, educators and leaders have come together to reach consensus regarding the guiding principles and fundamental spirit of the practice of case management. As initially presented and with each subsequent revision, the *Standards of Practice for Case Management* have been based on an understanding that case management is not a specific health care profession, but rather an advanced practice within the varied health

care professions that serves as a foundation for case management. Therefore, the Standards described within this document are not intended to be a structured recipe for the delivery of case management interventions. Rather, they are offered to present a range of core functions, roles, responsibilities, and relationships that are integral to the practice of case management.

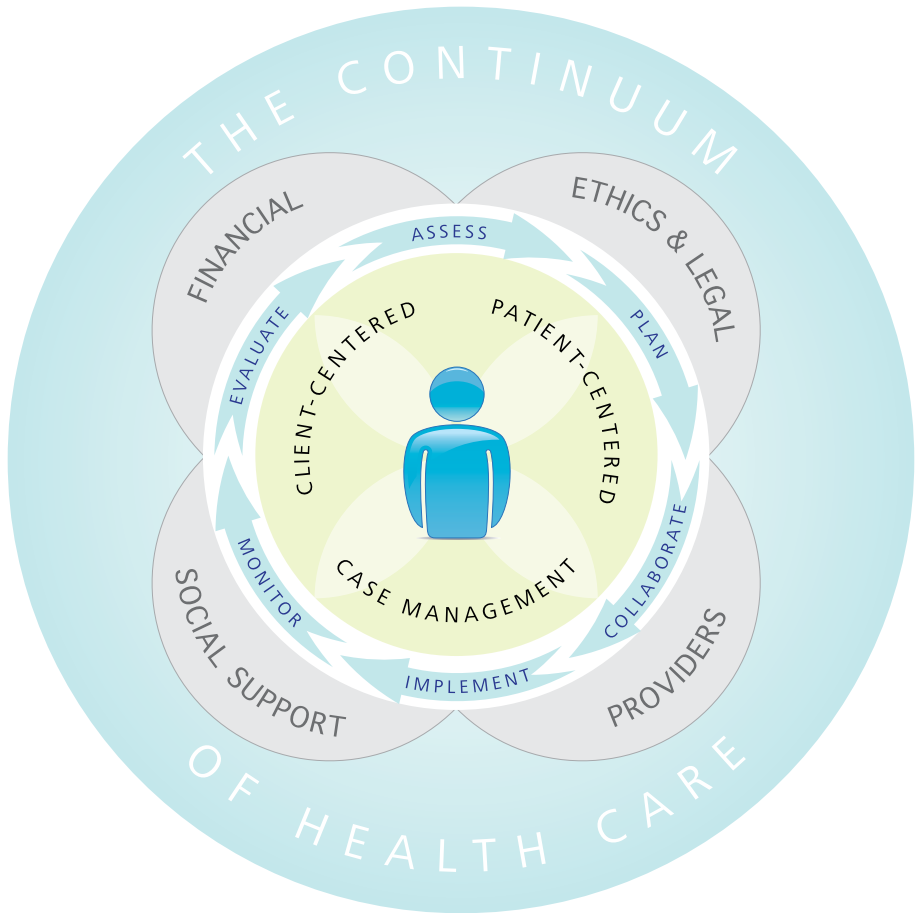
The nature of the written word has limitations, and definitions used in the Standards required much discussion. With the exception of the Continuum of Health Care figure (See page 5) where two terms (client and patient) are reflected, *the word "client" is used throughout these Standards to mean the recipient of case management services.* This individual may be a patient, beneficiary, injured worker, claimant, enrollee, member, college student, resident, or health care consumer of any age group. However, "client" can also mean something very different than the end-user of case management services; a client can also imply the business relationship with a company who contracts, or pays, for case management services.

To further define the recipients of case management interventions, the term "*support system*" is used. This *support system* is defined by each client and may include biological relatives, spouses, partners, friends, neighbors, colleagues, or any individual who *supports* the client. Note that sometimes when using the term "client," it may also be inclusive of the client's support system.

Another decision made was use of *case management*, rather than *care management*. These two terms are further defined in the Glossary, but for consistency, case management is used throughout this document.

Some adjustments may be necessary as these Standards are incorporated into

The Continuum of Health Care



individual practices. For example, where these Standards used the word “client,” you may choose to substitute *resident, consumer, beneficiary, individual*, or another term.

While the Standards are offered to standardize the process of case management, they are also intended to be realistically attainable by individuals who use appropri-

ate and professional judgment regarding the delivery of case management services to targeted client populations.

Additionally, the Standards may serve to present a portrait of the scope of case management practice to our colleagues and to the health care consumers that work in partnership with the case management professional.

II. Evolution of the Standards of Practice for Case Management

A. Standards of Practice for Case Management (1995)

In 1995, the President of the CMSA wrote a foreword in the 1995 *CMSA Standards of Practice*. In it he stated that the “*development of national Standards represents a major step forward for case managers. The future of our practice lies in the quality of our performance, as well as our outcomes*” (CMSA, 1995, pg.3). These first Standards included this definition of case management (CMSA, 1995, pg.8):

Case management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes.

The 1995 *Standards of Practice* were recognized as an anticipated tool that case management would utilize within every case management practice arena. They were seen as a guide to move case management practice to excellence. The Standards explored the planning, monitoring, evaluating and outcomes phases, followed by Performance Standards for the practicing case manager. The Performance Standards addressed how the case manager worked within each of the established Standards and with other disciplines to follow all legal requirements.

Even at this first juncture, the Standards committee recognized the importance of the case managers basing their individual practice on valid research findings and they encouraged case managers to participate in the research process, programs, and development of specific tools for the practice of case management. This was evidenced by key sections that highlighted measurement criteria in

the collaborative, ethical, and legal sections (CMSA, 1995).

B. Standards of Practice for Case Management (2002)

The 2001 Board of Directors for CMSA identified the need for a careful and thorough review and, if appropriate, revision of the initial published Standards. The revised *Standards of Practice for Case Management* were published in 2002. The published definition of case management was amended to (CMSA, 2002, pg. 5):

Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes.

The section on Performance Indicators was expanded to further define the case manager. The purpose of case management was revised to address quality, safety and cost-effective care, as well as to focus upon facilitating appropriate access to care.

Primary case management functions in 2002 included both current and new skills and concepts: positive relationship-building; effective written/verbal communication; negotiation skills; knowledge of contractual and risk arrangements, the importance of obtaining consent, confidentiality, and client privacy; attention to cultural competency; ability to effect change and perform ongoing evaluation; use of critical thinking and analysis; ability to plan and organize effectively; promote client autonomy and self-determination; and knowledge of funding sources, health care services, human behavior dynamics, health care delivery and financing systems, and clinical standards and outcomes.

Standards of Practice for Case Management

■ IEHP Medicare DualChoice HMO SNP

Case management work applied to individual clients or to groups of clients, such as in disease management or population health models. The facilitation section included more detail about the importance of communication and collaboration on behalf of the client and the payer. The practice settings for case management were increased to capture the evolution of, and the increase in, the number of venues in which case managers worked.

C. **Standards of Practice for Case Management (2010)**

The *Standards of Practice for Case Management* 2010 include topics that influence the practice of case management in the current health care environment. Included in this revision are:

- Addressing the total individual, inclusive of medical, psychosocial, behavioral, and spiritual needs.
- Collaborating efforts that focus upon moving the individual to self-care whenever possible.
- Increasing involvement of the individual and caregiver in the decision-making process.
- Minimizing fragmentation of care within the health care delivery system.
- Using evidence-based guidelines, as available, in the daily practice of case management.
- Focusing on transitions of care, which includes a complete transfer to the next care setting provider that is effective, safe, timely, and complete.

Improving outcomes by utilizing adherence guidelines, standardized tools, and proven processes to measure a client's understanding and acceptance of the proposed plans, his/her willingness to change, and his/her support to maintain health behavior change.

- Expanding the interdisciplinary team to include clients and/or their identified support system, health care providers, including community-based and facility-based professionals (i.e., pharmacists, nurse practitioners, holistic care providers, etc.).
- Expanding the case management role to collaborate within one's practice setting to support regulatory adherence.
- Moving clients to optimal levels of health and well-being.
- Improving client safety and satisfaction.
- Improving medication reconciliation for a client through collaborative efforts with medical staff.
- Improving adherence to the plan of care for the client, including medication adherence.

These changes advance case management credibility and complement the current trends and changes in health care. Future case management *Standards of Practice* will likely reflect the existing climate of health care and build upon the evidence-based guidelines that are proven successful in the coming years.

III. Definition of Case Management

The basic concept of case management involves the timely coordination of quality services to address a client's specific needs in a cost-effective manner in order to promote positive outcomes. This can occur in a single health care setting or during the client's transitions of care throughout the care continuum. The case manager serves as an important facilitator among the client, family or caregiver, the health team, the payer, and the community.

As demonstrated in the section on the *Evolution of the Standards of Case Management*, the definition of case management has evolved over a period of time; it reflects the vibrant and dynamic progression of the standards of practice.

Following more than a year of study and discussion with members of the National Case Management Task Force, the CMSA's Board of Directors approved a definition of case management in 1993.

Since that time, the CMSA Board of Directors has repeatedly reviewed and analyzed the definition of case management to ensure its continued application in a dynamic health environment. The definition was modified in 2002 to reflect the process of case management outlined within the Standards. The definition was again revisited in 2009 and modified to further align with the current practice of case management.

While there are many definitions of case management, the 2009 definition approved by CMSA is as follows (CMSA, 2009):

Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes.

IV. Philosophy and Guiding Principles

A. Statement of Philosophy

A philosophy is a statement of belief that sets forth principles to guide a program and the individual in his/her practice of that program (Powell & Tahan, 2008). The CMSA's philosophy of case management statement articulates that (CMSA, 2009):

The underlying premise of case management is based in the fact that, when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, the health care delivery systems and the various reimbursement sources. Case management serves as a means for achieving client wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. ... Case management services are best offered in a climate that allows direct communication between the case manager, the client, and appropriate service personnel, in order to optimize the outcome for all concerned.

The philosophy of case management underscores the recommendation that individuals, particularly those experiencing catastrophic injuries or severely chronic illnesses, be evaluated for case management services. The key philosophical components of case management address care that is holistic and client-centered, with mutual goals, allowing stewardship of resources for the client and the health care system. Through these efforts, case management focuses simultaneously on achieving health and maintaining wellness to the highest level possible for each client.

It is the philosophy of case management that when health care is appropriately and efficiently provided, all parties benefit. The provision of case management, working collaboratively with the health care team in complex situations, serves to identify care options which are acceptable to the client. This will, in turn, increase adherence to the plan of care and successful outcomes. Case management reduces the fragmentation of care, which is too often experienced by clients who obtain health care services from multiple providers. Taken collectively, services offered by a case manager can enhance a client's safety, well-being and quality of life, while reducing total health care costs. Thus, effective case management can directly and positively affect the health care delivery system.

B. Guiding Principles

Guiding principles are relevant and meaningful concepts that clarify or guide practice. Guiding principles for case management practice include the following. Case managers:

- Use a client-centric, collaborative partnership approach.
- Whenever possible, facilitate self-determination and self-care through the tenets of advocacy, shared decision-making, and education.
- Use a comprehensive, holistic approach.
- Practice cultural competence, with awareness and respect for diversity.
- Promote the use of evidence-based care, as available.
- Promote optimal client safety.
- Promote the integration of behavioral change science and principles.

- Link with community resources.
- Assist with navigating the health care system to achieve successful care, for example during transitions.
- Pursue professional excellence and maintain competence in practice.
- Promote quality outcomes and measurement of those outcomes.
- Support and maintain compliance with federal, state, local, organizational, and certification rules and regulations.

interventions, and strategies are targeted at the achievement of client stability, wellness, and autonomy through advocacy, assessment, planning, communication, education, resource management, care coordination, collaboration, and service facilitation.

They are based on the needs and values of the client and are accomplished in collaboration with all service providers. This accomplishes care that is appropriate, effective, client-centered, timely, efficient, and equitable.

V. Case Management Practice Settings

Case management practice extends across all health care settings, including payer, provider, government, employer, community, and home environment. However, the practice varies in degrees of complexity and comprehensiveness based on the following four factors (Powell and Tahan, 2008):

1. The context of the care setting, such as wellness and prevention, acute, or rehabilitative.
2. The health conditions and needs of the patient population(s) served, as well as the needs of the family/caregivers, such as critical care, asthma, renal failure, hospice care.
3. The reimbursement method applied, such as managed care, workers' compensation, Medicare, or Medicaid.
4. The health care professional discipline designated as the case manager, such as registered nurse, social worker, physician, rehabilitation counselor, etc.

The following is a representative list of case management practice settings; however, it is not an exhaustive list of settings where case managers exist. Case managers work in:

- Hospitals and integrated care delivery systems, including acute care, sub-acute care, long-term acute care (LTAC) facilities, skilled nursing facilities (SNF), rehabilitation facilities.
- Ambulatory care clinics and community based organizations, including student/university counseling and health care centers.
- Corporations.
- Public health insurance programs, e.g., Medicare, Medicaid, state-funded programs.
- Private health insurance programs, e.g., workers' compensation, occupational health, disability, liability, casualty, automotive, accident and health, long-term care insurance, group health insurance, managed care organizations.
- Independent and private case management companies.
- Government-sponsored programs, e.g., correctional facilities, military health care/Veterans Administration, public health.
- Provider agencies and community facilities, i.e., mental health facilities, home health services, ambulatory and day care facilities.
- Geriatric services, including residential and assisted living facilities.
- Long-term care services, including home and community based services.
- Hospice, palliative, and respite care programs.
- Physician and medical group practices.
- Life care planning programs.
- Disease management companies.

VI. Case Management Roles, Functions, and Activities

It is necessary to differentiate between the terms “role,” “function,” and “activity,” before describing what case managers do. Defining these terms is essential to providing a clear and contextual understanding of the roles and responsibilities of case managers.

A *role* is a general and abstract term that refers to a set of behaviors and expected consequences that are associated with one’s position in a social structure. A *function* is a grouping of a set of specific tasks within the role. An *activity* is a discrete action or task a person performs to address the expectations of the role assumed (See Glossary) (Tahan, Huber, Downey, 2006).

A role tends to consist of several functions and each function is described through a list of specific activities. These descriptions constitute what is known as a “job description” (Tahan, Huber, Downey, 2006). The roles assumed by case managers vary based on the same four factors described in the section entitled, *Case Management Practice Setting*.

The case manager performs the primary functions of assessment, planning, facilitation and advocacy, which are achieved through collaboration with the client and other health care professionals involved in the client’s care. Key responsibilities of case management have been identified by nationally recognized professional societies and certifying bodies through case management roles and functions research.

It is not the intent of the Standards to parallel these key responsibilities; the Standards will broadly define major functions involved in the case management process to achieve desired outcomes.

Successful outcomes cannot be achieved without specialized skills and knowledge applied throughout the process. These skills include, but are not limited to, positive

relationship-building; effective written and verbal communication; negotiation; knowledge of contractual or risk arrangements; the ability to effect change, perform ongoing evaluation and critical analysis; and the ability to plan and organize effectively.

It is important for the case manager to have knowledge of funding sources, health care services, human behavior dynamics, the health care delivery and financing systems, and clinical standards and outcomes. The skills and knowledge base of a case manager may be applied to individual clients, or to groups of clients, such as in disease management or population health models.

Role functions of case managers include:

- Conducting a comprehensive assessment of the client’s health and psychosocial needs, including health literacy status and deficits, and develops a case management plan collaboratively with the client and family or caregiver.
- Planning with the client, family or caregiver, the primary care physician/provider, other health care providers, the payer, and the community, to maximize health care responses, quality, and cost-effective outcomes.
- Facilitating communication and coordination between members of the health care team, involving the client in the decision-making process in order to minimize fragmentation in the services.
- Educating the client, the family or caregiver, and members of the health care delivery team about treatment options, community resources, insurance benefits, psychosocial concerns, case management, etc., so that timely and informed decisions can be made.

- Empowering the client to problem-solve by exploring options of care, when available, and alternative plans, when necessary, to achieve desired outcomes.
- Encouraging the appropriate use of health care services and strives to improve quality of care and maintain cost effectiveness on a case-by-case basis.
- Assisting the client in the safe transitioning of care to the next most appropriate level.
- Striving to promote client self-advocacy and self-determination.
- Advocating for both the client and the payer to facilitate positive outcomes for the client, the health care team, and the payer. However, if a conflict arises, the needs of the client must be the priority.

VII. Components of the Case Management Process

The case management process is carried out within the ethical and legal realm of a case manager's scope of practice, using critical-thinking and evidence-based knowledge. The overarching themes in the case management process include the tasks described below.

However, note that case management is neither linear nor a one-way exercise. For example, the *assessment* responsibilities will occur at all points in the process, and functions such as *facilitation*, *coordination*, and *collaboration* will occur throughout the client's health care encounter.

Primary steps in the case management process include (Powell & Tahan, 2008):

1. *Client identification and selection:* Focuses on identifying clients who would benefit from case management services. This step may include obtaining consent for case management services, if appropriate.
2. *Assessment and problem/opportunity identification:* Begins after the completion of the case selection and intake into case management and occurs intermittently, as needed, throughout the case.
3. *Development of the case management plan:* Establishes goals of the intervention and prioritizes the client's needs, as well as determines the type of services and resources that are available in order to address the established goals or desired outcomes.
4. *Implementation and coordination of care activities:* Puts the case management plan into action.
5. *Evaluation of the case management plan and follow-up:* Involves the evaluation of the client's status and goals and the associated outcomes.
6. *Termination of the case management process:* Brings closure to the care and/or episode of illness. The process focuses on discontinuing case management when the client transitions to the highest level of function, the best possible outcome has been attained, or the needs/desires of the client change.

VIII. Standards of Case Management Practice

A. STANDARD: CLIENT SELECTION PROCESS FOR CASE MANAGEMENT

The case manager should identify and select clients who can most benefit from case management services available in a particular practice setting.

How Demonstrated:

- Documentation of consistent use of the selection process within the individual organization's policies and procedures.
- Use of high-risk screening criteria to assess for inclusion in case management programs. Examples of high-risk screening criteria include, but are not limited to:
 - Age
 - Poor pain control
 - Low functional status or cognitive deficits
 - Previous home health and durable medical equipment usage
 - History of mental illness or substance abuse, suicide risk, or crisis intervention
 - Chronic, catastrophic, or terminal illness
 - Social issues such as a history of abuse, neglect, no known social support, or lives alone
 - Repeated emergency department visits
 - Repeated admissions
 - Need for admission or transition to a post-acute facility
 - Poor nutritional status
 - Financial issues

B. STANDARD: CLIENT ASSESSMENT

The case manager should complete a health and psychosocial assessment, taking into account the cultural and linguistic needs of each client.

How Demonstrated:

- Documentation of client assessments using standardized tools, when appropriate. Example criteria may include, but are not limited to the following components (as pertinent to the case manager's practice setting):
 - Physical/functional
 - Medical history
 - Psychosocial behavioral
 - Mental health
 - Cognitive
 - Client strengths and abilities
 - Environmental and residential
 - Family or support system dynamics
 - Spiritual
 - Cultural
 - Financial
 - Health insurance status
 - History of substance use
 - History of abuse, violence, or trauma
 - Vocational and/or educational
 - Recreational/leisure pursuits
 - Caregiver(s) capability and availability
 - Learning and technology capabilities
 - Self-care capability
 - Health literacy
 - Health status expectations and goals
 - Transitional or discharge plan
 - Advance care planning
 - Legal

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- Transportation capability and constraints
- Health literacy and illiteracy
- Readiness to change
- Documentation of resource utilization and cost management; current diagnosis(es); past and present course and services; prognosis; goals (short and long term); provider options; and available health care benefits.
- Evidence of use of relevant, comprehensive information and data required for client assessment from many sources including, but not limited to:
 - Client interviews
 - Initial assessment and ongoing assessments
 - Family or caregivers, physicians, providers, other members of the interdisciplinary health care team
 - Medical records
 - Data: claims and/or administrative

C. STANDARD: PROBLEM/OPPORTUNITY IDENTIFICATION

The case manager should identify problems or opportunities that would benefit from case management intervention.

How Demonstrated:

- Documentation of agreement among the client, family or caregiver, and other providers and organizations regarding the problems/opportunities identified.
- Documented identification of opportunities for intervention, such as:
 - Lack of established, evidenced-based plan of care with specific goals
 - Over-utilization or under-utilization of services
 - Use of multiple providers/agencies
 - Use of inappropriate services or level of care

- Non-adherence to plan of care (e.g. medication adherence)
- Lack of education or understanding of:
 - The disease process
 - The current condition(s)
 - The medication list
- Medical, psychosocial, mental health and/or functional limitations
- Lack of a support system or presence of a support system under stress.
- Financial barriers to adherence of the plan of care
- Determination of patterns of care or behavior that may be associated with increased severity of condition.
- Compromised client safety
- Inappropriate discharge or delay from other levels of care
- High cost injuries or illnesses
- Complications related to medical, psychosocial or functional issues
- Frequent transitions between settings

D. STANDARD: PLANNING

The case manager should identify immediate, short-term, long-term, and ongoing needs, as well as develop appropriate and necessary case management strategies and goals to address those needs.

How Demonstrated:

- Documentation of relevant, comprehensive information and data using interviews, research, and other methods needed to develop a plan of care.
- Recognition of the client's diagnosis, prognosis, care needs, preferences, preferred role in decision-making, and outcome goals of the plan of care.
- Validation that the plan of care is consistent with evidence-based practice, when such guidelines are available and applicable.

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changes in the client's condition, lack

- Establishment of measurable goals and indicators within specified time frames. Example measures could include access to care, cost-effectiveness of care, and quality of care.
- Documentation of client's or client's support system participation in the written case management plan of care; documentation of agreement with plan, including agreement with any changes or additions.
- Facilitation of problem-solving and conflict resolution.
- Evidence of supplying the client with information and resources necessary to make informed decisions.
- Awareness of maximization of client outcomes by all available resources and services.
- Compliance with payer expectations with respect to how often to contact and reevaluate the client or redefine long or short term goals.

**E. STANDARD:
MONITORING**

The case manager should employ ongoing assessment and documentation to measure the client's response to the plan of care.

How Demonstrated:

- Documentation of ongoing collaboration with the client, family or caregiver, providers, and other pertinent stakeholders, so that the client's response to interventions is reviewed and incorporated into the plan of care.
- Verification that the plan of care continues to be appropriate, understood, accepted by client and support system, and documented.
- Awareness of circumstances necessitating revisions to the plan of care, such as

of response to the care plan, preference changes, transitions across settings, and barriers to care and services.

- Collaboration with the client, providers, and other pertinent stakeholders regarding any revisions to the plan of care.

**F. STANDARD:
OUTCOMES**

The case manager should maximize the client's health, wellness, safety, adaptation, and self-care through quality case management, client satisfaction, and cost-efficiency.

How Demonstrated:

- Evaluation of the extent to which the goals documented in the plan of care have been achieved.
- Demonstration of the efficacy, quality, and cost-effectiveness of the case manager's interventions in achieving the goals documented in the plan of care.
- Measurement and reporting of the impact of the plan of care.
- Utilization of adherence guidelines, standardized tools and proven processes. These can be used to measure individuals' preference for, and understanding of:
 - The proposed plans for their care
 - Their willingness to change
 - Their support to maintain health behavior change
- Utilization of evidence-based guidelines in appropriate client populations.
- Evaluation of client satisfaction with case management.

**G. STANDARD:
TERMINATION OF CASE
MANAGEMENT SERVICES**

The case manager should appropriately terminate case management services based upon

established case closure guidelines. These guidelines may differ in various case management practice settings.

How Demonstrated:

- Identification of reasons for case management termination, such as:
 - Achievement of targeted outcomes or maximum benefit reached
 - Change of health setting
 - Loss or change in benefits (i.e., client no longer meets program or benefit eligibility requirements)
 - Client refuses further medical/psychosocial services
 - Client refuses further case management services
 - Determination by the case manager that he/she is no longer able to perform or provide appropriate case management services (e.g., non-adherence of client to plan of care)
 - Death of the client
- Evidence of agreement of termination of case management services by the client, family or caregiver, payer, case manager, and/or other appropriate parties.
- Documentation of reasonable notice of termination of case management services that is based upon the facts and circumstances of each individual case.
- Documentation of both verbal and/or written notice of termination of case management services to the client and to all treating and direct service providers.
- With permission, communication of client information to transition providers to maximize positive outcomes.

**H. STANDARD:
 FACILITATION, COORDINATION,
 AND COLLABORATION**

The case manager should facilitate coordination, communication, and collaboration with

How Demonstrated:

- Recognition of the case manager’s professional role and practice setting in relation to that of other providers and organizations caring for the client.
- Development and maintenance of proactive, client-centered relationships and communication with the client, and other necessary stakeholders to maximize outcomes.
- Evidence of transitions of care, including:
 - A transfer to the most appropriate health care provider/setting
 - The transfer is appropriate, timely, and complete
 - Documentation of collaboration and communication with other health care professionals, especially during each transition to another level of care within or outside of the client’s current setting
- Adherence to client privacy and confidentiality mandates during collaboration.
- Use of mediation and negotiation to improve communication and relationships.
- Use of problem-solving skills and techniques to reconcile potentially differing points of view.
- Evidence of collaborative efforts to optimize client outcomes: this may include working with community, local and state resources, primary care physician or other primary provider, other members of the health care team, the payer, and other relevant health care stakeholders.
- Evidence of collaborative efforts to maximize regulatory adherence within the case manager’s practice setting.

**I. STANDARD:
QUALIFICATIONS FOR
CASE MANAGERS**

Case managers should maintain competence in their area(s) of practice by having one of the following:

- a) Current, active, and unrestricted licensure or certification in a health or human services discipline that allows the professional to conduct an assessment independently as permitted within the scope of practice of the discipline; **and/or**
- b) Baccalaureate or graduate degree in social work, nursing, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the persons being served. The degree must be from an institution that is fully accredited by a nationally recognized educational accreditation organization, and the individual must have completed a supervised field experience in case management, health, or behavioral health as part of the degree requirements.

How Demonstrated:

- Possession of the education, experience, and expertise required for the case manager's area(s) of practice.
- Compliance with national and/or local laws and regulations that apply to the jurisdictions(s) and discipline(s) in which the case manager practices.
- Maintenance of competence through relevant and ongoing continuing education, study, and consultation.
- Practicing within the case manager's area(s) of expertise, making timely and appropriate referrals to, and seeking consultation with, others when needed.

**J. STANDARD:
LEGAL**

The case manager should adhere to applicable local, state, and federal laws, as well

NOTE: In the event that employer policies or the policies of other entities are in conflict with applicable legal requirements, the case manager should understand which laws prevail. In these cases, case managers should seek clarification of any questions or concerns from an appropriate and reliable expert resource, such as an employer, government agency, or legal counsel.

**1. Standard:
Confidentiality and Client Privacy**

The case manager should adhere to applicable local, state, and federal laws, as well as employer policies, governing the client, client privacy, and confidentiality rights and act in a manner consistent with the client's best interest.

How Demonstrated:

- Up-to-date knowledge of, and adherence to, applicable laws and regulations concerning confidentiality, privacy, and protection of client medical information issues.
- Evidence of a good faith effort to obtain the client's written acknowledgement that he/she has received notice of privacy rights and practices.

**2. Standard:
Consent for Case Management
Services**

The case manager should obtain appropriate and informed client consent before case management services are implemented.

How Demonstrated:

- Evidence that the client and support system were thoroughly informed with

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regard to:

- Proposed case management process and services relating to the client's health conditions and needs
- Possible benefits and costs of such services
- Alternatives to the proposed services
- Potential risks and consequences of the proposed services and alternatives
- Client's right to refuse the proposed case management services, and potential risks and consequences related to such refusal

- Evidence that the information was communicated in a client-sensitive manner, which is intended to permit the client to make voluntary and informed care choices.
- If client consent is a prerequisite to the provision of case management services, documentation of the informed consent.

K. STANDARD: ETHICS

Case managers should behave and practice ethically, adhering to the tenets of the code of ethics that underlies his/her professional credential (e.g., nursing, social work, rehabilitation counseling, etc.).

How Demonstrated:

- Awareness of the five basic ethical principles and how they are applied: beneficence (to do good), nonmaleficance (to do no harm), autonomy (to respect individuals' rights to make their own decisions), justice (to treat others fairly), and fidelity (to follow-through and to keep promises).
- Recognition that a case manager's primary obligation is to his/her clients.
- Maintenance of respectful relationships with coworkers, employers, and other professionals.

■ Recognition that laws, rules, policies, insurance benefits, and regulations are sometimes in conflict with ethical principles. In such situations, case managers are bound to address such conflicts to the best of their abilities and/or seek appropriate consultation.

L. STANDARD: ADVOCACY

The case manager should advocate for the client at the service-delivery, benefits-administration, and policy-making levels.

How Demonstrated:

- Documentation demonstrating:
 - Promotion of the client's self-determination, informed and shared decision-making, autonomy, growth, and self-advocacy
 - Education of other health care and service providers in recognizing and respecting the needs, strengths, and goals of the client
 - Facilitating client access to necessary and appropriate services while educating the client and family or caregiver about resource availability within practice settings
 - Recognition, prevention, and elimination of disparities in accessing high-quality care and client health care outcomes as related to race, ethnicity, national origin, and migration background; sex, sexual orientation, and marital status; age, religion, and political belief; physical, mental, or cognitive disability; gender, gender identity, or gender expression; or other cultural factors
 - Advocacy for expansion or establishment of services and for client-centered changes in organizational and governmental policy

- Recognition that client advocacy can sometimes conflict with a need to balance cost constraints and limited resources. Documentation indicates that the case manager weighed decisions with the intent to uphold client advocacy, whenever possible.

**M. STANDARD:
CULTURAL COMPETENCY**

The case manager should be aware of, and responsive to, cultural and demographic diversity of the population and specific client profiles.

How Demonstrated:

- Documentation demonstrating:
 - Case manager understands relevant cultural information and communicates effectively, respectfully, and sensitively within the client's cultural context
 - Assessment of client linguistic needs and identifying resources to enhance proper communication. This may include use of interpreters and material in different languages and formats, as necessary, and understanding of cultural communication patterns of speech volume, context, tone, kinetics, space, and other similar verbal/non-verbal communication patterns
- Evidence of pursuit of education in cultural competence to enhance the case manager's effectiveness in working with multicultural populations.

**N. STANDARD:
RESOURCE MANAGEMENT
AND STEWARDSHIP**

The case manager should integrate factors related to quality, safety, access, and cost-effectiveness in assessing, monitoring, and evaluating resources for the client's care.

- Documentation of evaluating safety, effectiveness, cost, and potential outcomes when designing care plans to promote the ongoing care needs of the client.
- Evidence of follow-through on care plan objectives, including assisting with referral and outsourcing as needed, based on the ongoing care needs of the client and the competency, knowledge, and skill of the health and human services providers.
- Evidence of utilizing evidence-based guidelines, as available, and guidelines specific to the case manager's practice setting in making decisions about resource allocation and utilization.
- Demonstration of linking the client and family or caregiver with resources appropriate to the needs and goals identified in the care plan. Fully informing the client and family or caregiver of the length of time for which each resource is available, their financial responsibility for each resource, and the anticipated outcome of resource utilization.
- Documented communication of the client and other providers, both internal and external, especially during care transitions or when there is a significant change in the client's situation.
- Evidence of promoting the most effective and efficient use of health care services and financial resources.
- Documentation demonstrating that the intensity of case management services rendered corresponds with the needs of the client.

**O. STANDARD:
RESEARCH AND RESEARCH
UTILIZATION**

The case manager should maintain familiarity with current research findings and be able to apply them, as appropriate, in his/her practice.

How Demonstrated:

- Evidence of familiarization with current literature pertaining to the case manager's expertise, and regular participation

- Compliance with legitimate and relevant research efforts, in order to quantify and define valid and reliable outcomes in case management.
- Incorporation of meaningful research findings into practice as appropriate.
- Participation in identification of practical, hands-on approaches to case management "best practices."

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X. Glossary

Activity: A discrete action or task a person performs to meet the expectations of the role assumed. For example, an acute care case manager “completes concurrent reviews” with a payer-based case manager (Tahan, Huber, Downey, 2006).

Advocacy: The act of recommending, pleading the cause of another; to speak or write in favor of.

Assessment: A systematic process of data collection and analysis involving multiple elements and sources.

Care Coordination: The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care (AHRQ, 2007).

Care Management: A health care delivery process that helps achieve better health outcomes by anticipating and linking clients with the services they need more quickly. Case management may help to avoid unnecessary services by reducing medical complications (CCMC, 2009). This term often refers to the management of long-term health care, legal, and financial services by professionals serving social welfare, aging and nonprofit care delivery systems. Services are delivered under a psychological model (Powell & Tahan, 2008).

Case Management: A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to facilitate an indi-

vidual’s and family’s comprehensive health needs through communication and available resources to promote quality cost-effective outcomes (CMSA, 2010).

Case Management Plan of Care:

A comprehensive plan that includes a statement of problems/needs determined upon assessment; strategies to address the problems/needs; and measurable goals to demonstrate resolution based upon the problem/need, the time frame, the resources available, and the desires/motivation of the client.

Case Management Process: The manner in which case management functions are performed, including: assessment, problem identification, outcome identification, planning, monitoring, and evaluating.

Certification: A process by which a government or non-government agency grants recognition to those who have met predetermined qualifications as set forth by a credentialing body.

Client: (1) Individual who is the recipient of case management services. This individual can be a patient, beneficiary, injured worker, claimant, enrollee, member, college student, resident, or health care consumer of any age group. In addition, when *client* is used, it may also infer the inclusion of the client’s support. (2) Client can also imply the business relationship with a company who contracts for or pays for case management services. The first definition is the one used throughout the *Standards of Practice 2010*.

Client Support System: The client’s support system is defined by each client and may include biological relatives, spouses, partners, friends, neighbors, colleagues, or any individual who supports the client.

Consumer: An individual person who is the direct or indirect recipient of the services of the organization. Depending on the context, consumers may be identified by different names, such as “member,” “enrollee,” “beneficiary,” “patient,” “injured worker,” “claimant,” etc. A consumer relationship may exist even in cases where there is not a direct relationship between the consumer and the organization. For example, if an individual is a member of a health plan that relies on the services of a utilization management organization, then the individual is a consumer of the utilization management organization.

Cultural Competence: The process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each (NASW, 2007).

Culture: The integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. Culture may include, but is not limited to, race, ethnicity, national origin, and migration background; sex, sexual orientation, and marital status; age, religion, and political belief; physical, mental, or cognitive disability; gender, gender identity, or gender expression (Cross, Bazron, Dennis, & Isaacs, as cited in U.S. Department of Health and Human Services, Office of Minority Health, 2001).

Disease Management: Disease management is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. Because of the presence of co-morbidities or multiple conditions in most high-risk patients, this approach may become operationally difficult to execute,

Over time, the industry has moved more toward a whole person model in which all the diseases a patient has are managed by a single disease management program (DMAA definition).

Evidence-Based Criteria: Guidelines for clinical practice that incorporate current and validated research findings.

Family: Family members and/or those individuals designated by the client as the client’s support system.

Function: A grouping of a set of specific tasks within the role. The set of tasks that constitutes one function tends to focus on a common theme and share the same goal; for example, “evaluation of outcomes” or “coordination of treatments” (Tahan, Huber, Downey, 2006).

Health: In addition to the four definitions of “health” listed below, case management’s definition of health takes on a more comprehensive meaning that includes biopsychosocial, as well as educational and vocational, aspects of the client:

1. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO Constitution).
2. The extent to which an individual or a group is able to realize aspirations and satisfy needs, and to change or cope with the environment. Health is a resource for everyday life, not the objective of living; it is a positive concept, emphasizing social and personal resources as well as physical capabilities (Health Promotion: A Discussion Document, Copenhagen: WHO 1984).
3. A state characterized by anatomic, physiologic and psychological integrity; ability to perform personally valued family, work

and community roles; ability to deal with physical, biologic, psychological and social stress; a feeling of well-being; and freedom from the risk of disease and untimely death (J. Stokes et al. "Definition of terms and concepts applicable to clinical preventive medicine," J Common Health, 1982; 8:33-41).

4. A state of equilibrium between humans and the physical, biologic and social environment, compatible with full functional activity (JM. Last, Public Health and Human Ecology, 2nd ed. Stamford, CT: Appleton and Lange, 1997).

Health Outcomes: Changes in current or future health status of individuals or communities that can be attributed to antecedent actions or measures (EURO European Centre for Health Policy, ECHP, Brussels, 1999).

Health Services: Medical services and/or health and human services.

Kinetics: A communication pattern referring to the use of stance, gestures, eye behavior and other posturing by an individual in non-verbal communication.

Licensure: Licensure is a process by which a government agency grants permission to an individual to engage in a given occupation, provided that person possesses the minimum degree of competency required to reasonably protect public health, safety, and welfare.

Managed Care: Services or strategies designed to improve access to care, quality of care, and the cost-effective use of health resources. Managed care services include, but are not limited to, case management, utilization management, peer review, disease management, and population health.

Medical Home: A medical home model provides accessible, continuous, coordinated and comprehensive patient-centered care, and is managed centrally by a primary care physician with the active involvement of non-physician

home may receive supplemental payments to support operations expected of a medical home. Physician practices may be encouraged or required to improve practice infrastructure and meet certain qualifications in order to achieve eligibility.

Outcomes: Measurable results of case management interventions, such as client knowledge, adherence, self-care, satisfaction, and attainment of a meaningful lifestyle.

Payer: An individual or entity that funds related services, income, and/or products for an individual with health needs.

Predictive Modeling: Modeling is the process of mapping relationships among data elements that have a common thread. Through predictive modeling, data is "mined" with software to examine and recognize patterns and trends, which can then potentially forecast clinical and cost outcomes. This allows an organization to make better decisions regarding current/future staff and equipment expenditures, provider and client education needs, allocation of finances, as well as to better risk stratify population groups.

Provider: The individual, service organization, or vendor who provides health care services to the client.

Risk Stratification: The process of categorizing individuals and populations according to their likelihood of experiencing adverse outcomes, e.g., high risk for hospitalization.

Role: A general and abstract term that refers to a set of behaviors and expected consequences that are associated with one's position in a social structure. Usually, organizations and employers use a person's title as a proxy for his/her role; for example, "acute care case manager" (Tahan, Huber, Downey, 2006).

Space: A communication pattern referring to the physical distance or "comfort proximity"

selected by an individual when communicating with another individual.

Speech Context: A communication pattern referring to the use/non-use of emotion by an individual in verbal communication.

Speech Volume: A communication pattern referring to the level of loudness or softness used by an individual in verbal communication.

Standard: An authoritative statement agreed to and promulgated by the practice by which the quality of practice and service can be judged.

Transitional Care: Transitional care includes all the services required to facilitate the coordination and continuity of health care as the patient moves between one health care service provider to another.

Transitions of Care: Transitions of care is the movement of patients from one health care practitioner or setting to another as their condition and care needs change. Also known as "care transitions."

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**OVERVIEW OF CALIFORNIA CHILDREN'S (CCS)
MEDICAL ELIGIBILITY**

Determination of Medical Eligibility

Medical eligibility for the CCS program, as specified in CCR, Title 22, Division 2, Part 2, Subdivision 7, CC5, Chapter 4, Medical Eligibility, Sections 41811 through 41876 shall be determined by the CCS program medical consultant or designee through the review of medical records that document the applicant's medical history, results of a physical examination by a physician, laboratory results, radiologic findings, or other tests that support the diagnosis of the eligible condition.

Infectious-Diseases (CCR, Title 22, Section 41811)

CCS applicants diagnosed with the following shall be medically eligible for participation in the CCS program:

- A. Infections of the bone such as osteomyelitis and periostitis
- B. Infections of the eye when the infections, if untreated, may result in permanent visual impairment or blindness
- C. Infections of the central nervous system producing a neurologic impairment that results in physical disability requiring surgery or rehabilitation services to regain or improve function, such as movement or speech, which was limited or lost as a result of the infection
- D. Infections acquired in utero and for which medically necessary postnatal treatment is required, such as toxoplasmosis, cytomegalovirus infection, rubella, herpes simplex, and syphilis
- E. Human Immunodeficiency Virus (HIV infection), when confirmed by laboratory tests

Neoplasms (CCR, Title 22, Section 41815)

CCS applicants diagnosed with the following shall be medically eligible for participation in the CCS program:

- A. All malignant neoplasms, including leukemia
- B. Benign neoplasms when either of the following is present:
 - 1. The neoplasm produces a deformity that is visibly abnormal in appearance
 - 2. The neoplasm is located contiguous to or within a vital organ or body part, and its continued growth would limit or eliminate the function of the organ or body part or lead to the death of the applicant



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Endocrine, Nutritional, and Metabolic Diseases Immune Disorders (CCR, Title 22, Section 41819)

CCS applicants with the following conditions shall be medically eligible for participation in the CCS program:

- A. Diseases of the pituitary, thyroid, parathyroid, thymus, and adrenal glands
- B. Growth hormone deficiency when certain specific criteria are met
- C. Diseases of the ovaries or testicles in which there is delayed onset of puberty primary amenorrhea after the age of 15 years, sexual development prior to the age of eight years, feminization of a male, or virilization of a female
- D. Diseases of the pancreas resulting in pancreatic insufficiency
- E. Diabetes mellitus
- F. Diseases due to congenital or acquired immunologic deficiency manifested by life-threatening infections, as determined from medical information about the applicant's clinical course and laboratory studies
- G. Inborn errors of metabolism such as phenylketonuria, homocystinuria, galactosemia, glycogen storage disease and maple syrup urine disease
- H. Cystic fibrosis

Diseases of Blood and Blood-Forming Organs (CCR, Title 22, Section 41823)

CCS applicants with the following conditions shall be medically eligible for participation in the CCS program:

- A. Anemias due to abnormal production of red cells or hemoglobin
- B. Anemias resulting solely from a nutritional deficiency, such as inadequate intake of iron, folic acid or Vitamin B12 are eligible only when they present with life-threatening complications
- C. Hemolytic anemias such as, but not limited to, congenital spherocytosis, sickle cell disease, the thalassemias and erythroblastosis fetalis
- D. Hemolytic anemias resulting from infection are eligible only when they present with life-threatening complications
- E. Pancytopenias, such as the congenital and acquired aplastic anemias
- F. Disorders of leukocytes such as acquired and congenital neutropenia and chronic granulomatous disease
- G. Hemorrhagic diseases due to:
 - 1. Coagulation disorders such as the hemophilias and von Willebrand disease
 - 2. Disorders of platelets that are life-threatening
 - 3. Other disorders of blood and blood-forming organs that are life-threatening such as polycythemia and hypersplenism



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Mental Disorders and Mental Retardation (CCR, Title 22, Section 418270)

- A. CCS applicants with a mental disorder, whose application is based upon such a disorder, shall not be medically eligible for the CCS program.
- B. CCS applicants with mental retardation, whose application is based upon such disease, shall not be medically eligible for the CCS program.

Diseases of the Nervous System (CCR, Title 22, Section 41831)

CCS applicants with the following conditions shall be medically eligible for participation in the CCS program:

- A. Non-infectious diseases of the central and peripheral nervous system which produce a neurologic impairment that is life-threatening or disabling
- B. Cerebral palsy, a non-progressive motor disorder with onset in early childhood resulting from a lesion in the brain manifested by the presence of one or more of the following:
 - 1. rigidity or spasticity
 - 2. hypotonia, with normal or increased deep tendon reflexes, and exaggeration of or persistence of primitive reflexes beyond the normal range
 - 3. involuntary movements that are described as athetoid, choreoid, or dystonic
 - 4. ataxia, incoordination of voluntary movement, dysdiadochokinesia, intention tremor, reeling or shaking of trunk and head, staggering or stumbling, and broad-based gait
- C. Seizure disorder when either of the following occur:
 - 1. It is secondary to a CCS-eligible condition
 - 2. It is of unknown origin and one of the following exists:
 - a. The frequency or duration of the seizures requires more than four changes in dosage or type of medications in the 12 months preceding the initial or subsequent determination of medical eligibility
 - b. The frequency or duration of the seizures requires two or more types of seizure medications each day
 - c. The frequency or duration of the seizures requires at least a monthly medical office visit for assessment of the applicant's clinical status and periodic blood tests for medication levels or presence of blood dyscrasia
- D. The applicant has experienced an episode of Status Epilepticus in which case medical eligibility shall extend for one year following that event
- E. When the eligibility criteria listed in subsection (c)(2) above have not been present for at least one year, eligibility shall cease.



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Medical Therapy Program

- A. CCS applicants with one of the following conditions shall be medically eligible for participation in the CCS Medical Therapy Program:
 - 1. Cerebral palsy as specified in Section 41831 (b)
 - 2. Neuromuscular conditions that produce muscle weakness and atrophy, such as poliomyelitis, myasthenias, and muscular dystrophies
 - 3. Chronic musculoskeletal and connective tissue diseases or deformities such as osteogenesis imperfecta, arthrogryposis, rheumatoid arthritis, amputations, and contractures resulting from burns
 - 4. Other conditions manifesting the findings listed in Section 41831 (b) above such as, ataxias, degenerative neurological disease, or other intracranial processes
- B. CCS applicants under three years of age shall be eligible when two or more of the following neurological findings are present:
 - 1. Exaggerations of or persistence of primitive reflexes beyond the normal age (corrected for prematurity)
 - 2. Increased Deep Tendon Reflexes (DTRs) that are 3+ or greater
 - 3. Abnormal posturing as characterized by the arms, legs, head, or trunk turned or twisted into an abnormal position
 - 4. Hypotonicity, with normal or increased DTRs, in infants below one year of age (infants above one year must meet criteria described in [a][1])
 - 5. Asymmetry of neurologic motor findings of trunk or extremities

Diseases of the Eye (CCR, Title 22, Section 41835)

CCS applicants with the following eye conditions shall be medically eligible for participation in the CCS program:

- A. Strabismus, when surgery is required and either until fusion is obtained, or a visibly abnormal deformity is corrected
- B. Infections that produce permanent visual impairment or blindness, such as keratitis and choroiditis
- C. Infections that require repeated ophthalmological treatment or surgery, such as chronic dacryocystitis
- D. Other diseases that can lead to permanent visual impairment such as:
 - 1. Cataract
 - 2. Glaucoma
 - 3. Retinal detachment
 - 4. Optic atrophy
 - 5. Optic neuritis
 - 6. Lens dislocation
 - 7. Retinopathy of prematurity
 - 8. Persistent hyperplastic primary vitreous



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- 9. Ptosis
- E. Congenital anomalies of the eye which meet the criteria of Section 41868

Diseases of the Ear and Mastoid Process (CCR, Title 22, Section 41839)

- A. CCS applicants shall be eligible for participation in the CCS program for diagnostic services to determine the presence of a hearing loss when the applicant:
 - 1. Fails two pure tone audiometric hearing screening tests performed no more than six weeks apart at levels not to exceed 25 decibels and at the minimum number of frequencies of 1000, 2000, and 4000 hertz; or
 - 2. Fails to have normal auditory brain stem evoked response, or otoacoustic emission or behavioral responses to auditory stimuli as determined by two tests performed at least six weeks apart; or
 - 3. Fails to pass hearing screening provided through the Newborn and Infant Hearing Screening, Tracking and Intervention Program, as per CA Health and Safety Code Sections 123975 and 124115 through 124120.5. or
 - 4. Exhibits symptoms that may indicate a hearing loss such as poor speech for age or delay in age appropriate behavioral milestones or
 - 5. Has documentation of risk factors associated with a sensorineural hearing or conductive hearing loss such as:
 - a. A family history of congenital or childhood onset of hearing impairment
 - b. Congenital infection known or suspected to be associated with hearing loss
 - c. Craniofacial anomalies
 - d. Hyperbilirubinemia at a level exceeding the indication for an exchange transfusion
 - e. Ototoxic medications used for more than five days
 - f. Bacterial meningitis
 - g. Severe depression at birth, defined as:
 - (1) Apgar score of three or less, or
 - (2) Failure to initiate spontaneous respirations by ten minutes of age, or
 - (3) Hypotonia persisting to two hours of age.
 - h. Receiving prolonged mechanical ventilation for a duration of at least ten days
 - i. Presence of findings of a syndrome known to be associated with hearing loss
 - 6. There are symptoms that may indicate a hearing loss such as poor speech for age or delay in age-appropriate behavioral milestones
- B. If either of the tests referenced (a) (1) and (2) above are performed by an audiologist or otolaryngologist, only one exam shall be required for eligibility for diagnostic testing.
- C. CCS applicants shall be eligible for participating in the CCS program for treatment services when there is a hearing loss present as defined by the following criteria:



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1. In children over five years of age, a pure tone audiometric loss of 30 decibels or greater at two or more frequencies in the same ear tested at 500, 1000, 2000, 3000, 4000, 6000, 8000 hertz or a loss of 40 decibels or greater at any one frequency between and including 500 through 8000 hertz
 2. In children from three to five years of age, a pure tone audiometric loss of 30 decibels or greater at any frequency tested at 500, 1000, 2000, 3000, 4000, 6000, 8000 hertz
 3. In children unable to complete a pure tone audiometric test and whose auditory brain stem evoked response, or otoacoustic emission, or behavioral responses to auditory stimuli indicate hearing loss of 30 decibels or greater
- D. CCS applicants shall be eligible for participation in the CCS program for treatment services when there is:
1. Perforation of the tympanic membrane that requires tympanoplasty
 2. Mastoiditis
 3. Cholesteatoma
- E. Congenital anomalies of the ear and mastoid process that meet the criteria of Section 41868

Diseases of the Circulatory System (CCR, Title 22, Section 41844)

CCS applicants with the following conditions shall be medically eligible for participation in the CCS program:

- A. Diseases of the endocardium, myocardium, or pericardium
- B. Cardiac dysrhythmia requiring medication or surgery
- C. Diseases of blood vessels such as embolism, thrombosis, aneurysms, and periarteritis
- D. Cerebral and subarachnoid hemorrhage. Neonates with cerebral and subarachnoid hemorrhage shall only be eligible if they meet the criteria listed in Section 41870 (b).
- E. Chronic diseases of the lymphatic system
- F. Primary hypertension that requires medication to control
- G. Congenital anomalies of the circulatory system that meet the criteria of CCR, Title 22, Division 2, Part 2, Subdivision 7, CCS, Chapter 4, Medical Eligibility, Section 41868

Diseases of the Respiratory System (CCR, Title 22, Section 41848)

CCS applicants with chronic conditions of the lower respiratory tract, such as the following conditions, shall be eligible for participation in the CCS program:

- A. Chronic pulmonary infections such as abscess or bronchiectasis
- B. Cystic fibrosis
- C. Chronic Lung Disease (CLD) of infancy, such as Bronchopulmonary Dysplasia (BPD), when one or two of the following criteria is met:
 1. History of care in a neonatal intensive care unit that includes all of the following:



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- a. Mechanical ventilation for more than six days
- b. Concentration of oxygen greater than 60 percent for more than four of the days of ventilation
- c. Need for supplemental oxygen for more than 30 days
2. Infants who do not have the above history shall be eligible when at least one of the following is present:
 - a. radiographic changes characteristic of CLD such as areas of hyperinflation, areas of radiolucency, and areas of radio density due to peribronchial thickening or patchy atelectasis
 - b. impaired pulmonary function, as manifested by one or more of the following during a stable phase: increased airway resistance, increased residual capacity, decreased dynamic compliance, arterial CO₂ tension (PaCO₂) greater than 45 or arterial O₂ tension (PaO₂) less than 80
 - c. presence of cardiovascular sequelae such as pulmonary or systemic hypertension or right or left ventricular hypertrophy
- D. Asthma, when it has produces chronic lung disease
- E. Chronic lung diseases that are the result of chemical injury, metabolic disorders, genetic defects, or immunologic disorders other than asthma
- F. Respiratory failure requiring ventilatory assistance
- G. Hyaline membrane disease; or
- H. Congenital anomalies of the respiratory system that meet the criteria of Section 41868

Diseases of the Digestive System (CCR, Title 22, Section 41852)

CCS applicants with the following conditions shall be eligible for participation in the CCS program:

- A. Diseases of the liver including:
 1. acute liver failure
 2. chronic liver disease
- B. Disorders of the gastrointestinal tract including:
 1. chronic inflammatory diseases requiring complex ongoing medical management or surgical intervention such as peptic ulcer, ulcerative colitis, regional enteritis, diverticulitis, and cholecystitis
 2. chronic intestinal failure
 3. gastroesophageal reflux when:
 - a. it is part of or complicates the management of a CCS-eligible condition or
 - b. it is an isolated condition with complications such as esophageal stricture or chronic aspiration pneumonia
 - c. congenital anomalies of the digestive system that meet the criteria of Section 41868
- C. Malocclusion, when the condition and the applicant meet the following criteria as determined by the CCS Orthodontic Screening Program:



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1. There is severe impairment of occlusal function such as overbite, crossbite, or open bite, or there is severe facial deformity as determined through the CCS orthodontic screening program
2. The applicant shall have good oral hygiene as determined by a history of brushing and flossing and the absence of untreated dental caries.
3. The applicant shall agree to cooperate and comply with the prescribed treatment plan by keeping appointments and following the instructions of the treating orthodontist.

Diseases of the Genitourinary System (CCR, Title 22, Section 41856)

CCS applicants with the following conditions shall be medically eligible for participation in the CCS program:

- A. Acute glomerulonephritis in the presence of acute renal failure, malignant hypertension, or congestive heart failure
- B. Chronic glomerulonephritis, nephrosis, or the nephrotic syndrome
- C. Chronic renal insufficiency
- D. Renal calculus
- E. Obstructive uropathies that require surgery
- F. Vesicoureteral reflux, grade II or greater;
- G. Congenital anomalies of the genitourinary tract that meet the criteria of Section 41868

Complications of Pregnancy, Childbirth, and Puerperium

Prenatal care and delivery may be provided if the pregnancy complications the management of the CCS-eligible chronic disease (e.g., cystic fibrosis, diabetes, chronic renal or cardiac disease).

Diseases of the Skin and Subcutaneous Tissues (CCR, Title 22, Section 41864)

CCS applicants with the following conditions shall be medically eligible for participation in the CCS program:

- A. Persistent, progressive diseases of the subcutaneous tissue, such as pemphigus and epidermolysis bullosa, which are disabling or life-threatening, and require multidisciplinary management
- B. Scars when surgery is required and one of the following criteria is met:
 1. There is limitation of or loss of mobility of a major joint, such as the ankle, knee, hip, wrist, elbow, or shoulder
 2. They are disabling and disfiguring
- C. Congenital anomalies of the skin or subcutaneous tissue



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Diseases of the Musculoskeletal System and Connective Tissue (CCR, Title 22, Section 41866)

CCS applicants with at least one of the following conditions shall be medically eligible for participation in the CCS program:

- A. Acute and chronic suppurative infections of the joint
- B. Chronic, progressive or recurrent inflammatory disease of the connective tissue or joints, such as rheumatoid arthritis, inflammatory polyarthropathy, lupus erythematosus, dermatomyositis, and scleroderma
- C. Chronic, progressive, or degenerative diseases of muscles and fascia, such as myasthenia, myotonia, dystrophies, and atrophies that lead to atrophy, weakness, contracture and deformity, and motor disability
- D. Intervertebral disc herniation
- E. Scoliosis with a greater than 20 degree curvature
- F. Other disease of the bones and joints resulting in limitation of normal function and requiring surgery, complex bracing, or more than two castings
- G. Congenital anomalies of the musculoskeletal system or connective tissue that meet criteria of section 41868

Minor orthopedic conditions, such as tibia torsion, femoral anteversion, knock knees, pigeon toes, and flat feet, which only require special shoes, splints, and/or simple bracing are not eligible.

Congenital Anomalies (CCR, Title 22, Section 41868)

- A. CCS applicants with congenital anomalies shall be medically eligible for participation in the CCS program when the congenital anomaly is amenable to cure, correction, or amelioration; and
 - 1. Limits or compromises a body function based on a combination of factors such as its size, type and location; or
 - 2. Is severely disfiguring
- B. The following conditions shall not be medically eligible for the CCS program when the application for eligibility is based solely on their presence:
 - 1. Inguinal and umbilical hernia
 - 2. Hydrocele
 - 3. Undescended testicle(s)

Perinatal Morbidity and Mortality (CCR, Title 22, Section 41870)

CCS applicants with the following conditions shall be medically eligible when care is provided in a CCS-approved neonatal intensive care unit (NICU):



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- A. Infants who are identified to have a CCS-eligible medical condition and who require care in an NICU because of their need for the services defined in (b) or (c) below.
- B. Neonates and infants, who do not have an identified CCS-eligible condition but who develop a disease or condition which requires one of the medically necessary items listed in (1) through (5) below when delivered in a CCS-approved NICU:
 - 1. Invasive or non-invasive ventilatory assistance
 - 2. Supplemental oxygen concentration of greater than or equal to 60 percent for more than 24 hours duration
 - 3. Maintenance of an umbilical artery catheter or peripheral arterial catheter for monitoring arterial blood pressure or for sampling of blood for monitoring arterial blood gases
 - 4. Maintenance of a central venous catheter for the administration of hyperalimentation
 - 5. Chest tube
- C. Neonates and infants, who do not have an identified CCS-eligible condition but who develop a disease or condition that requires two or more of the medically necessary items listed in (1) through (7) below when delivered in a CCS-approved NICU:
 - 1. Ten or more episodes per day of apnea and bradycardia which require either external stimulation or treatment with medications such as theophylline or caffeine
 - 2. Pulmonary percussion, vibration, and suction given every six hours or at least four times per day
 - 3. Supplemental inspired oxygen given for greater than 48 hours duration
 - 4. A peripheral intravenous line for administration of medications or intravenous fluids
 - 5. Peripheral hyperalimentation
 - 6. Tracheal suctioning every hour
 - 7. Continuous gavage feeding, gavage feeding every two hours or less, or oral feeding requiring more than 30 minutes
- D. When a neonate or infant no longer requires medically necessary services listed in (b) or (c) above, medical eligibility for the CCS program for NICU care shall cease.

Accidents, Poisonings, Violence, and Immunizations Reactions **(CCR, Title 22, Section 41872)**

CCS applicants with the following conditions shall be medically eligible for participation in the CCS program:

- A. Injuries of organ systems or organs as defined below when the injuries can result in permanent disability or death if treatment is not provided:
 - 1. Central or peripheral nervous system, when the injury may produce paralysis, atrophy, or ataxia



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2. Vital or multiple organs including the eye and ear
- B. Fractures of the skull, spine, pelvis, or femur which, if untreated, would result in permanent loss or limitation of function or death
- C. Burns, when one of the following is present:
 1. Second and third degree burns of greater than ten percent of the body surface area for children less than ten years of age;
 2. Second and third degree burns of greater than twenty percent of the body surface for children greater than ten years of age;
 3. Third degree burns of greater than five percent of the body surface area for any age group;
 4. Burns involving signs or symptoms of inhalation injury or causing respiratory distress;
 5. Second or third degree burns of the face, ear, the mouth and throat, genitalia, perineum, major joints, the hands or the feet; or
 6. Electrical injury or burns, including burns caused by lightning;
- D. Presence of a foreign body when the object, if not surgically removed, would result in death or a permanent limitation or compromise of a body function
- E. Ingestion of drugs or poisons that result in life threatening events and require inpatient hospital treatment
- F. Lead poisoning as defined as a confirmed blood level of 20 micrograms per deciliter or above
- G. Poisonous snake bites that require complex medical management and that may result in severe disfigurement, permanent disability or death
- H. Other envenomation, such as spider bites, that require complex medical management and that may result in severe disfigurement, permanent disability or death; or
- I. Severe adverse reactions to an immunization requiring extensive medical care

This brief summary document has been developed solely for the convenience and use in understanding the general medical eligibility criteria of the CCS program. It is not an authoritative statement of, and may not be cited as authority, for any decisions, determinations or interpretations under the CCS program.

NEW REFERRAL CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information			
1. Date of request	2. Provider name	3. Provider number	
4. Address (number, street)		City	State ZIP code
5. Contact person	6. Contact telephone number ()	7. Contact fax number ()	

Client Information			
8. Client name—last		first	middle
9. Alias (AKA)	10. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	11. Date of birth (mm/dd/yy)	
12. CCS/GHPP case number	13. Contact phone number ()	14. Medical record number (hospital or office)	
15. Residence address (number, street) (DO NOT USE P.O. BOX)		City	State ZIP code
16. Mailing address (if different) (number, street, P.O. box number)		City	State ZIP code
17. County of residence	18. Language spoken	19. Name of parent/legal guardian	
20. Mother's first name	21. Primary care physician (if known)	22. Primary care physician telephone number ()	

Insurance Information		
23.a. Enrolled in Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No		23.b. If yes, client index number (CIN)
24. Enrolled in Healthy Families <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, name of plan
25. Enrolled in commercial insurance plan <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, type of commercial insurance plan <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Other
		Name of plan
23.c. Client's Medi-Cal number		

Diagnosis		
26. Diagnosis (DX)/ICD-9: _____ DX/ICD-9: _____ DX/ICD-9: _____		

Requested Services						
27.* CPT-4/ HCPCS Code/NDC	28. Specific Description of Service/Procedure	29. From (mm/dd/yy)	To (mm/dd/yy)	30. Frequency/ Duration	31. Units	32. Quantity (Pharmacy Only)

* A specific procedure code/NDC is required in column 27 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.

33. Other documentation attached <input type="checkbox"/> Yes	34. Enter facility name (where requested services will be performed, if other than office).
--	---

Inpatient Hospital Services		
35. Begin date	36. End date	37. Number of days

Additional Services Requested from Other Health Care Providers

38. Provider's name		Provider number	Telephone number ()	Contact person
Address (number, street)		City	State	ZIP code
Description of services		Procedure code	Units	Quantity
Additional information				

39. Provider's name		Provider number	Telephone number ()	Contact person
Address (number, street)		City	State	ZIP code
Description of services		Procedure code	Units	Quantity
Additional information				

40. Signature of physician/provider or authorized designee	41. Date
--	----------

Instructions

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Provider number: Enter billing number (no group numbers).
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.

Client Information

8. Client name: Enter the client's name—last, first, and middle.
9. Alias (AKA): Enter the patient's alias, if known.
10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
12. CCS/GHPP case number: Enter the client's CCS/GHPP number. If not known, leave blank.
13. Contact phone number: Enter the phone number where the client or client's legal guardian can be reached.
14. Medical record number: Enter the client's hospital or office medical record number.
15. Residence address: Enter the address of the client. Do not use a P.O. Box number.
16. Mailing address: Enter the mailing address if it is different than number 15.
17. County of residence: Enter residential county of the client.
18. Language spoken: Enter the client's language spoken.
19. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
20. Mother's first name: Enter the client's mother's first name.
21. Primary care physician: Enter the client's primary care physician's name. If it is not known, enter NK (not known).
22. Primary care physician telephone number: Enter the client's primary care physician phone number.

Insurance Information

- 23a. Enrolled in Medi-Cal? Mark the appropriate box. If the answer is yes, enter the client's index number in box 23.b. and the client's Medi-Cal number in box 23.c.
24. Enrolled in Healthy Families: Mark the appropriate box. If the answer is yes, enter the name of the plan.
25. Enrolled in a commercial insurance plan? Mark the appropriate box, if the answer is yes, mark the type of insurance plan and enter the name of the commercial insurance plan on the line provided.

Diagnosis

26. Diagnosis and/or ICD-9: Enter the diagnosis or ICD-9 code, if known, relating to the requested services.

Requested Services

27. CPT-4/HCPSC code/NDC: Enter the CPT-4, HCPSC code or NDC code being requested. This is only required if services requested are other than ongoing physician authorizations or special care center authorizations. Also not required for inpatient hospital stay requests.
28. Specific description of procedure/service: Enter the specific description of the procedure/service being requested.
29. From and to dates: Enter the date you would like the services to begin. Enter the date you would like the services to end. These dates are not necessarily the dates that will be authorized.
30. Frequency/duration: Enter the frequency or duration of the procedures/service being requested.
31. Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
32. Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
33. Other documentation attached: Check this box if attaching additional documentation.
34. Enter facility name: Complete this field with the name of the facility where you would like to perform the surgery you are requesting.

Inpatient Hospital Services

35. Begin date: Enter the date the requested inpatient stay shall begin.
36. End date: Enter the end date for the inpatient stay requested.
37. Number of days: Enter the number of days for the requested inpatient stay.

Additional Services Requested from Other Health Care Providers

38. and 39. Provider's name: Enter name of the provider you are referring services to.
Provider number: Enter the provider's provider number.
Telephone: Enter provider's telephone number.
Contact person: Enter the name of the person who can be contacted regarding the request.
Address: Enter address of the provider.
Description of services: Enter description of referred services.
Procedure code: Enter the procedure code for requested service other than ongoing physician services.
Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
Additional information: Include any written instructions/details here.

Signature

40. Signature of physician or provider: Form must be signed by the physician, pharmacist, or authorized representative.
41. Date: Enter the date the request is signed.

ESTABLISHED CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request	2. Provider name	3. Provider number
4. Address (number, street)		City State ZIP code
5. Contact person	6. Contact telephone number ()	7. Contact fax number ()

Client Information

8. Client name—last		First	Middle
9. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	10. Date of birth (mm/dd/yyyy)		11. CCS/GHPP case number
12. Client index number (CIN)		13. Client's Medi-Cal number	

Diagnosis

14. Diagnosis (DX)/ICD-9: _____ DX/ICD-9: _____ DX/ICD-9: _____

15. Service Authorization Request for *(Check one)*
 a. CCS/GHPP New SAR
 b. Authorization extension (If checked, enter authorization number: _____)

Requested Services

16.* CPT-4/ HCPCS Code/NDC	17. Specific Description of Service/Procedure	18. From (mm/dd/yy)	To (mm/dd/yy)	19. Frequency/ Duration	20. Units	21. Quantity (Pharmacy Only)

* A specific procedure code/NDC is required in column 16 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.

22. Other documentation attached <input type="checkbox"/> Yes	23. Enter facility name (where requested services will be performed, if other than office.)
--	---

24. Begin date	25. End date	26. Number of days	27. Extension begin date	28. Extension end date	29. Number of extension days
----------------	--------------	--------------------	--------------------------	------------------------	------------------------------

Additional Services Requested from Other Health Care Providers

30. Provider's name		Provider number	Telephone number ()	Contact person
Address (number, street)		City	State	ZIP code
Description of services		Procedure code	Units	Quantity
Additional information				

31. Provider's name		Provider number	Telephone number ()	Contact person
Address (number, street)		City	State	ZIP code
Description of services		Procedure code	Units	Quantity
Additional information				

32. Signature of physician/provider or authorized designee	33. Date
--	----------

INSTRUCTIONS

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Provider number: Enter billing number (no group numbers).
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.

Client Information

8. Client name: Enter the client's name—last, first, and middle.
9. Gender: Check the appropriate box.
10. Date of birth: Enter the client's date of birth.
11. CCS/GHPP case number: Enter the client's CCS/GHPP number. If not known, leave blank.
12. Client index number (CIN): Enter the client's CIN number. If not known, leave blank.
13. Client's Medi-Cal number: Enter the client's Medi-Cal number. If number is not known, leave blank.

Diagnosis

14. Diagnosis and/or ICD-9: Enter the diagnosis or ICD-9 code, if known, relating to the requested services.

Requested Services

15. a. CCS/GHPP New SAR: Check if requesting a new authorization for an established CCS/GHPP client.
b. Authorization extension: Check if requesting an extension of an authorized request. Please enter the authorization number on the line.
16. CPT-4/HCPCS code/NDC: Enter the requested CPT-4, HCPCS code, or NDC code. This is only required if services requested are other than ongoing physician authorizations or special care center authorizations. Also not required for inpatient hospital stay requests.
17. Specific description of procedure/service: Enter the specific description of the procedure/service being requested.
18. From and to dates: Enter the date you would like the services to begin. Enter the date you would like the services to end. These dates are not necessarily the dates that will be authorized.
19. Frequency/duration: Enter the frequency or duration of the procedures/services being requested.
20. Units: For NDC, enter the total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
21. Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
22. Other documentation attached: Check this box if attaching additional documentation.
23. Enter facility name: Complete this field with the name of the facility where you would like to perform the surgery you are requesting.

Inpatient Hospital Services

24. Begin date: Enter the date the requested inpatient stay will begin.
25. End date: Enter the date the requested inpatient stay will end.
26. Number of days: Enter the number of days for the requested inpatient stay.
27. Extension begin date: Enter the date the requested extension of authorized inpatient stay will begin.
28. Extension end date: Enter the date the requested extended stay will end.
29. Number of extension days: Enter number of days for the requested extension inpatient stay.

Additional Services Requested from Other Health Care Providers

30. and 31. Provider's name: Enter name of the provider you are referring services to.
Provider number: Enter the provider's provider number.
Telephone: Enter provider's telephone number.
Contact person: Enter the name of the person who can be contacted regarding the request.
Address: Enter address of the provider.
Description of services: Enter description of referred services.
Procedure code: Enter the procedure code for requested service other than ongoing physician services.
Units: For NDC, enter the total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
Additional information: Include any written instructions/details here.

Signature

32. Signature of physician or provider: Form must be signed by the physician, pharmacist, or authorized representative.
33. Date: Enter the date the request is signed.



INLAND EMPIRE HEALTH PLAN

IEHP Medicare DualChoice HMO SNP

DIRECTORY OF LOCAL CCS APPROVED HOSPITALS

County: Riverside

Corona Regional Medical Center (Limited)

(Outpatient Only)

800 South Main Street Telephone: 951-737-4343
Corona, CA 92882

Desert Hospital (Standard)*

Neonatal Intensive Care Unit – Community (NICU, PICU)

Williams Phaklides, M.D., Director

1150 North Indian Canyon Avenue

Palm Springs, CA 92262 Telephone: 760-323-6511

Eisenhower Medical Center

(Outpatient only)

39000 Bob Hope Drive

Rancho Mirage, CA 92270 Telephone: 760-340-3911

Hemet Valley Medical Center

(Outpatient only)

1117 E. Devonshire Ave.

Hemet, CA 92543 Telephone: 951-652-2811

Inland Valley Regional Medical Center

(Outpatient only)

36485 Inland Valley Drive

Wildomar, CA 92595 Telephone: 951-677-1111

John F. Kennedy Memorial Hospital

(Outpatient only)

47111 Monroe Street

Indio, CA 92201 Telephone: 760-347-6161

Menifee Valley Medical Center

(Outpatient only)

28400 McCall Blvd.

Sun City, CA 92586 Telephone: 951-679-8888

**Moreno Valley Community Hospital
(Outpatient only)**

27300 Iris Ave.
Moreno Valley, CA 92586 Telephone: 951-243-0811

Parkview Community Hospital (Standard)*

Neonatal Intensive Care Unit – Community (NICU, Peds)
Marc Leitner, M.D., Director
3865 Jackson Street
Riverside, CA 92503 Telephone: 951-688-2211

Riverside County Regional Medical Center*

Neonatal Intensive Care Unit – Community (NICU, PICU, Peds)
Zentay Zoltan, M.D., Director
26520 Cactus Avenue
Moreno Valley, CA 92555 Telephone: 951- 486-4000

Riverside Community Hospital (NICU, Peds)*

4445 Magnolia Avenue
Riverside, CA 92501 Telephone: 951-788-3000

**San Geronio Memorial Hospital
(Outpatient only)**

600 N Highland Springs Ave.
Banning, CA 92220 Telephone: 951-845-1121

**Rancho Springs Medical Center
(Outpatient Only)**

25500 Medical Center Drive
Murrieta, CA 92362 Telephone: 951-696-6000

DIRECTORY OF LOCAL CCS APPROVED HOSPITALS

County: San Bernardino

Barstow Community Hospital

(Outpatient only)

555 S 7th Ave.

Barstow, CA 92311

Telephone: 760-256-1761

Kaiser Foundation Hospital (NICU, PICU)*

Neonatal Intensive Care Unit – Community (NICU, PICU)

Dilip R. Bhatt, M.D., Director

9961 Sierra Avenue

Fontana, CA 92335

Telephone: 909-427-5559

Loma Linda University Community Medical Center

25333 Barton Road

Loma Linda, CA 92354

Telephone: 909-796-0167

Loma Linda University Medical Center (Long Term)**

Neonatal Intensive Care Unit – Regional (NICU/Peds)

Gerald Nystrom, M.D., Director

Shamel Abd-Allah, MD., Director of Peds

11234 Anderson Street

Loma Linda, CA 92354

Telephone: 909-558-8000

Montclair Hospital Medical Center

(Outpatient only)

5000 San Bernardino St

Montclair, CA 91763

Telephone: 909-625-5411

Mountains Community Hospital

(Outpatient only)

29101 Hospital Rd

Lake Arrowhead, CA 92352

Telephone: 909-336-3651

Pomona Valley Hospital

Neonatal Intensive Care Unit – Community (NICU/Peds)

1798 N. Garey Avenue

Pomona, CA 91767

Telephone: 909-865-9500

Redlands Community Hospital (Standard)*

Neonatal Intensive Care Unit – Community (NICU & Peds)

Alan Wolpe, M.D., Director

350 Terraacina Blvd.

Redlands, CA 92373

Telephone: 909-335-5500

St. Bernardine Medical Center (Standard)*

Neonatal Intensive Care Unit – Community (NICU/Peds)
Thelma Yap, M.D., Director
2101 North Waterman Avenue
San Bernardino, CA 92402 Telephone: 909-883-8711

**Victor Valley Community Hospital
(Outpatient only)**

15248 11th St
Victorville, CA 92392 Telephone: 760-245-8691

San Bernardino Community Hospital (Standard)*

Neonatal Intensive Care Unit – Intermediate (NICU/Peds)
Cecilia S. Casaclang, M.D., Director
1805 Medical Center Drive
San Bernardino, CA 92411 Telephone: 909-887-6333

Arrowhead Regional Medical Center (Standard)*

Neonatal Intensive Care Unit – Intermediate (NICU/Peds)
Vellore G. Muraligopal, M.D., Director
400 North Pepper Avenue
Colton, CA 92324 Telephone: 909- 580-1000

* Standard: Community Hospital - capable of providing intermediate care not greater than 21 days. Generally with house staff that provide for acute and short-term conditions not requiring expertise in tertiary center.

** Long Term: Referral Hospital - tertiary level care, may be longer than 21 days. Teaching hospital, major affiliates with approved residency program in Pediatrics and other major specialties.

CALIFORNIA CHILDREN'S SERVICES PROGRAM Paneled Providers and Center Care

The CCS Program utilizes state-paneled providers. Physicians must be Board certified or eligible for certification and subsequently certified. State personnel review provider applications and approve providers to be CCS paneled. Applications are available from the state at (916) 653-8050 or (213) 897-3574.

A major goal of the CCS Program is to assure eligible children have access to multi-specialty and multi-disciplinary services. The program requires that children in need of such care receive it at CCS approved special care centers. Such children include, but are not limited to, those with congenital heart disease, inherited metabolic disorders, chronic renal disease, cystic fibrosis and other chronic lung disease, malignant neoplasms, hemoglobinopathies and hemophilia, craniofacial anomalies, myelomeningocele and endocrine disorders.

Special care centers are approved by the state CCS Program, whose professional staff conduct onsite reviews in consultation with experts in their respective areas of specialty. The CCS Program currently approves special care centers in the following areas:

- Amputee Center
- Bone Marrow Transplant
- Burn Centers
- Cardiac Center
- Cleft Palate Center
- Cochlear Implant Centers
- Communication Disorder Centers
- Craniofacial Center
- Cystic Fibrosis and Pulmonary Disease Center
- Extracorporeal Membrane Oxygenator (ECMO) Centers
- Gastrointestinal Center
- Heart Transplant Center
- Hematology/Oncology Center
- Hemophilia Center
- High Risk Infant Follow-up Centers
- Immunology/Infectious Disease Center
- Liver Transplant Center
- Lung and Heart-Lung Transplant Center
- Metabolic (Including PKU) and Endocrine Center
- Miscellaneous Center
- Musculoskeletal/Neuromusculoskeletal Centers
- Neonatal Intensive Care Unit - Community
- Neonatal Intensive Care Unit - Intermediate
- Neonatal Intensive Care Unit - Regional
- Pediatric Intensive Care Unit
- Prosthetic/Orthotic Center

- Rehabilitation Center
- Renal, Dialysis, and Transplant Center
- Sickle Cell Center
- Specified Inherited Neurologic Diseases Center
- Spina Bifida Centers

CCS approved special care centers in Riverside/San Bernardino County are:

<u>Center Type</u>	<u>Facility</u>
Cardiac Center	Loma Linda University Medical Center
Communication Disorder	Loma Linda University Medical Center
Craniofacial Center	Loma Linda University Medical Center
Cystic Fibrosis and Pulmonary Disease	Loma Linda University Medical Center Arrowhead Regional Medical Center
Heart Transplant Center	Loma Linda University Medical Center
Hematology/Oncology Center	Loma Linda University Medical Center San Bernardino Community Hospital
Hemophilia Center	Loma Linda University Medical Center San Bernardino Community Hospital
High Risk Infant Follow-up (Community)	Arrowhead Regional Medical Center Kaiser Hospital, Fontana Pomona Valley Hospital Medical Center Redlands Community Hospital Riverside Community Hospital Riverside County Regional Medical Center St Bernardine Medical Center
High Risk Follow-up (Intermediate)	San Bernardino Community Hospital
High Risk Infant Follow-up (Regional)	Loma Linda University Medical Center
Immunology/Infectious Disease	Loma Linda University Medical Center
Metabolic (including PKU) & Endocrine Center	Loma Linda University Medical Center
Extra Corporeal Membrane Oxygenation (ECMO)	Loma Linda University Medical Center

<u>Center Type</u>	<u>Facility</u>
Rheumatology Center	Loma Linda University Medical Center
Gastrointestinal Center	Loma Linda University Medical Center
Neonatal Intensive Care Unit - Community	Arrowhead Regional Medical Center Desert Hospital Kaiser Foundation Hospital - Fontana Parkview Community Hospital Pomona Valley Hospital Redlands Community Hospital Riverside County Regional Medical Center Riverside Community Hospital Saint Bernardine Medical Center
Neonatal Intensive Care Unit - Intermediate	San Bernardino Community Hospital
Neonatal Intensive Care Unit - Regional	Loma Linda University Medical Center
Pediatric Intensive Care Unit	Loma Linda University Medical Center Riverside County Regional Medical Center
Rehabilitation Center	Casa Colina Hospital - Pomona Loma Linda University Medical Center Ballard Rehabilitation Center
Renal, Dialysis, and Transplant Center	Loma Linda University Medical Center
Sickle Cell Center	Loma Linda University Medical Center
Spina Bifida Center	Loma Linda University Medical Center



INLAND EMPIRE HEALTH PLAN

PCP Referral to Behavioral Health (BH) Specialist

* Indicates Required Information

*PROVIDER INFORMATION: (Please Print Clearly)

Name, IEHP ID/NPI, Request Date, Address, City, ST Zip, Phone

*MEMBER INFORMATION: (Please Print Clearly)

Name, IEHP ID, Date Of Birth, Phone

REFERRAL INFORMATION:

*Major Presenting Problems (Select At Least One From Below)

Rating Of Level Of Severity: 1=Mild; 2=Moderate; 3=Severe; Leave Blank if Not Applicable. Anxiety, Depression, Sleep Disorder, Weight Change, Isolation, Obsessive/Compulsive, Aggressive Behavior, Assaultive Behavior, Conduct Disorder, Attention Problems, Concentration Difficulty, Confusion, Dementia, Dizziness, Light-Headed, Hallucination, Paranoia, Dissociative Process, Substance Abuse, Eating Disorder, Other.

*Behavioral Health Services Requested (Select At Least One From Below)

- 1. Counseling/Therapy
2. Psychiatric Evaluation/Psychotropic Medication
3. Substance Abuse

Comments: (Please Print Clearly)

Multiple horizontal lines for entering comments.



INLAND EMPIRE HEALTH PLAN

Behavioral Health (BH) Initial Evaluation Coordination of Care Report

* Indicates Required Information

***PROVIDER OF SERVICE INFORMATION:** *(Please Print Clearly)*

Name	IEHP ID/NPI	Auth #	Report Date
Address	City, ST Zip		Phone

***MEMBER INFORMATION:** *(Please Print Clearly)*

Name	IEHP ID	Date Of Birth	Phone
------	---------	---------------	-------

VISIT INFORMATION

***Patient Signed Release** Yes No *(If No, This Information Will NOT Be Forwarded To The PCP)*

Initial Visit Date: _____ **Concurrent BH Specialist:** _____

***Major Presenting Problems** *(Select At Least One From Below)*

Rating Of Level Of Severity: 1=Mild; 2=Moderate; 3=Severe; Leave Blank if Not Applicable

	1	2	3		1	2	3		1	2	3
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assaultive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hallucination <input type="checkbox"/> Auditory <input type="checkbox"/> Visual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Conduct Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paranoia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attention Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dissociative Process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concentration Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive/Compulsive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggressive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness, Light-Headed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

***Diagnosis** *(Complete At Least One (1) DX on Axis I or II, Axis IV, & Axis V)*

AXIS I – Primary Diagnosis: *(Enter a Valid AXIS I Code)*

AXIS I – Secondary Diagnosis: *(Enter a Valid AXIS I Code)*

AXIS II – Developmental Disorders And Personality Disorders: *(Enter a Valid AXIS II Code)*

AXIS III – Physical Disorders And Conditions – Optional: *(Enter a Valid AXIS III Code)*

AXIS IV – Psychosocial And Environmental Problems:

- | | |
|--|--|
| <input type="checkbox"/> Problems With Primary Support Group/Family | <input type="checkbox"/> Educational Problems |
| <input type="checkbox"/> Interpersonal Or Problems Related To The Social Environment | <input type="checkbox"/> Occupational Problems |
| <input type="checkbox"/> Problems Related To Interaction With The Legal System/Crime | <input type="checkbox"/> Housing Problems |
| <input type="checkbox"/> Problems With Access To Health Care | <input type="checkbox"/> Economic Problems |
| <input type="checkbox"/> Other Psychosocial And Environmental Problems | |

AXIS V – Global Assessment Of Functioning (GAF): Current: _____ Highest in Last Year: _____

CURRENT MEDICATIONS *(Please List All Known Medication)*

FINDINGS/RECOMMENDATIONS

1. Request For PCP To Provide

- | | |
|---|----------------|
| <input type="checkbox"/> Refer Patient Back To PCP To Evaluate Physical Complaints | Specify: _____ |
| <input type="checkbox"/> Refer Patient Back To PCP To Adjust Psychotropic Medications | Specify: _____ |

2. *Recommendation For Behavioral Health Treatment *(Select At Least One From Below)*

- a. SED Evaluation
- b. Individual Psychotherapy – Practitioner Recommended
 Self First Available IEHP Panel BH Practitioner Other: _____
- c. Family Therapy – Practitioner Recommended
 Self First Available IEHP Panel BH Practitioner Other: _____
- d. Group Therapy – Type
 ADHD Parent Training Pain Management Anxiety Management
 Depression Management Bereavement Other: _____
Group Therapy – Practitioner Recommended
 Self First Available IEHP Panel BH Practitioner Other: _____
- e. Psychiatric Evaluation/Psychotropic Medication Assessment – Practitioner Recommended
 Self First Available IEHP Panel BH Practitioner Other: _____
- f. Substance Abuse Services
Evaluation By Substance Abuse Specialists – Practitioner Recommended
 Self First Available IEHP Panel BH Practitioner Other: _____
- g. Evaluation For Detoxification – Practitioner Recommended
 Self First Available IEHP Panel BH Practitioner Other: _____
- h. Evaluation For Structured Outpatient Program
 Mental Health Substance Abuse Other Program: _____
- i. Other Services
 Specify: _____



INLAND EMPIRE HEALTH PLAN

IEHP Medicare DualChoice HMO SNP

SUBSTANCE ABUSE

IEHP Benefits: Detoxification is covered only when the inpatient admission is primarily due to an underlying medical condition, which requires acute inpatient care (e.g., myocardial infarction, CVA, etc.). Detoxification alone, as a reason for inpatient admission, is not covered.

Services for the treatment of chronic, medically uncomplicated drug dependence or alcoholism are not covered benefits. Patients requiring outpatient detoxification services are referred to the Short-Doyle Medi-Cal (SD/MC) program in the county where the Member resides.

See IEHP Provider Policy and Procedure Manual, “Benefit Manual” section, p. D-200.1, C-100.1).

-----Alternate Treatment Resources for Substance Abuse-----

24 Hour Detox Referral Line

(800) 499-3008

Alcohol and Drug Helpline

(800) 821-4357

California Department of Alcohol and Drug Programs

(800) 662-4357 or (800) 879-2772

National Cocaine Hotline

(800) 262-2463

Cocaine Anonymous (CA)

Inland Empire

(951) 359-3895

Narcotics Anonymous (NA)

Southern California

(800) 863-2962

Riverside County CARES (Community Access, Referrals, Evaluation, and Support) Line

(800) 706-7500

Sober Living Network

(800) 799-2084

Al-Anon and Alateen

(888) 425-2666

Alcohol and Drug Services

(909) 421-4601

National Council on Alcoholism and Drug Dependence Hopeline

(800) 622-2255

Marijuana Anonymous (MA)

(800) 766-6779

Alcoholics Anonymous (AA)

Inland Empire

(909) 825-4700

Riverside County Substance Abuse Program

(951) 782-2400

San Bernardino County Access Unit

(888) 743-1478

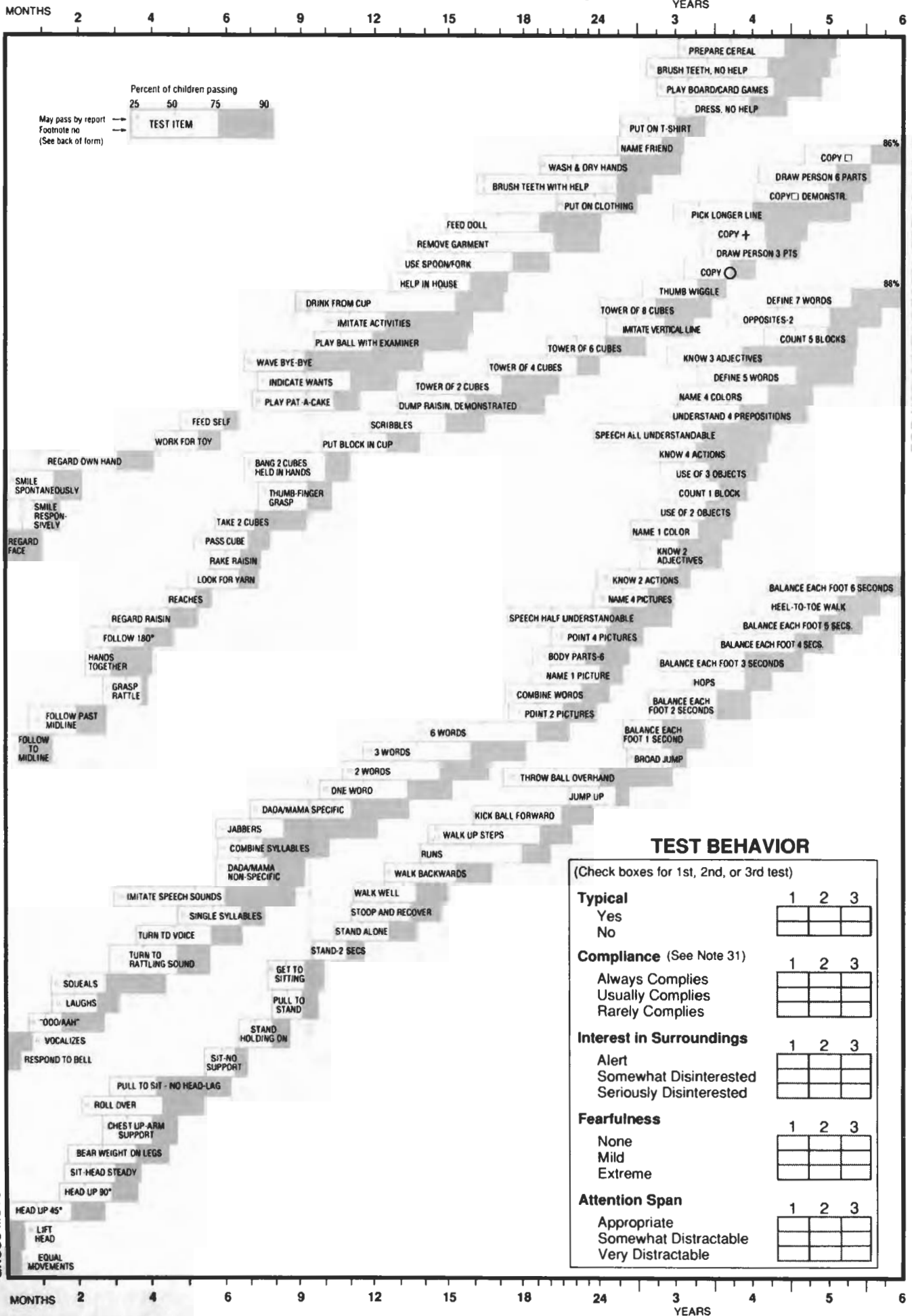
Denver II

DDM, INC. 1-800-419-4729
CATALOG #2115

Examiner: _____
Date: _____
Example Only
For ordering information call
1-800-419-4729

Name: _____
Birthdate: _____
ID No.: _____

Attachment 12-7
Denver Development Screening Tool
IEHP Medicare DualChoice HMO SNP

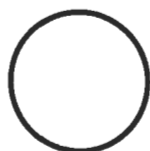


FOR USE OF THIS FORM - SEE AR 600-75

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DIRECTIONS FOR ADMINISTRATION

1. Try to get child to smile by smiling, talking or waving. Do not touch him/her.
2. Child must stare at hand several seconds.
3. Parent may help guide toothbrush and put toothpaste on brush.
4. Child does not have to be able to tie shoes or button/zip in the back.
5. Move yarn slowly in an arc from one side to the other, about 8" above child's face.
6. Pass if child grasps rattle when it is touched to the backs or tips of fingers.
7. Pass if child tries to see where yarn went. Yarn should be dropped quickly from sight from tester's hand without arm movement.
8. Child must transfer cube from hand to hand without help of body, mouth, or table.
9. Pass if child picks up raisin with any part of thumb and finger.
10. Line can vary only 30 degrees or less from tester's line. ✓
11. Make a fist with thumb pointing upward and wiggle only the thumb. Pass if child imitates and does not move any fingers other than the thumb.



12. Pass any enclosed form. Fail continuous round motions.



13. Which line is longer? (Not bigger.) Turn paper upside down and repeat. (pass 3 of 3 or 5 of 6)



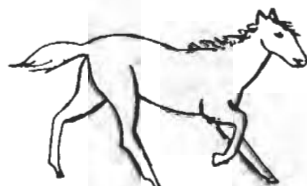
14. Pass any lines crossing near midpoint.

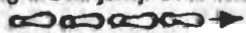


15. Have child copy first. If failed, demonstrate.

When giving items 12, 14, and 15, do not name the forms. Do not demonstrate 12 and 14.

16. When scoring, each pair (2 arms, 2 legs, etc.) counts as one part.
17. Place one cube in cup and shake gently near child's ear, but out of sight. Repeat for other ear.
18. Point to picture and have child name it. (No credit is given for sounds only.)
If less than 4 pictures are named correctly, have child point to picture as each is named by tester.



19. Using doll, tell child: Show me the nose, eyes, ears, mouth, hands, feet, tummy, hair. Pass 6 of 8.
20. Using pictures, ask child: Which one flies?... says meow?... talks?... barks?... gallops? Pass 2 of 5, 4 of 5.
21. Ask child: What do you do when you are cold?... tired?... hungry? Pass 2 of 3, 3 of 3.
22. Ask child: What do you do with a cup? What is a chair used for? What is a pencil used for?
Action words must be included in answers.
23. Pass if child correctly places and says how many blocks are on paper. (1, 5).
24. Tell child: Put block on table; under table; in front of me, behind me. Pass 4 of 4.
(Do not help child by pointing, moving head or eyes.)
25. Ask child: What is a ball?... take?... desk?... house?... banana?... curtain?... fence?... ceiling? Pass if defined in terms of use, shape, what it is made of, or general category (such as banana is fruit, not just yellow). Pass 5 of 8, 7 of 8.
26. Ask child: If a horse is big, a mouse is ___? If fire is hot, ice is ___? If the sun shines during the day, the moon shines during the ___? Pass 2 of 3.
27. Child may use wall or rail only, not person. May not crawl.
28. Child must throw ball overhand 3 feet to within arm's reach of tester.
29. Child must perform standing broad jump over width of test sheet (8 1/2 inches).
30. Tell child to walk forward,  heel within 1 inch of toe. Tester may demonstrate.
Child must walk 4 consecutive steps.
31. In the second year, half of normal children are non-compliant.

OBSERVATIONS:

IEHP Lab Order Form



INLAND EMPIRE HEALTH PLAN
A Public Entity

Claims Remittance To:
IEHP
Claims Department – Vision
P.O. Box 10129
San Bernardino, CA 92423

Member Name:		Member ID#:		Auth#:		Order Date:	
Date of Birth:		Tray#:			Date Received:		
	SPHERE	CYLINDER	AXIS	PD		PRISM	BASE
				FAR	NEAR		
R							
L							
CHECK APPROPRIATE LENS STYLE							
SINGLE VISION		BIFOCAL		TRIFOCAL		MATERIAL	
<input type="checkbox"/> SINGLE VISION V2100		<input type="checkbox"/> ROUND 22 V2200-28		<input type="checkbox"/> FLAT 28 V2200-28 <input type="checkbox"/> FLAT 35 V2200-35		<input type="checkbox"/> FLAT 7X28 50% Intermed V2300	
<input type="checkbox"/> CR-39		<input type="checkbox"/> GLASS					
ADD	SEG HEIGHT		TINT: *Must include medical justification in special instructions				
R			<input type="checkbox"/> UV V2755	<input type="checkbox"/> PNK 1 2 V2740	<input type="checkbox"/> BRN 1 2 3 V2740	<input type="checkbox"/> GRY 1 2 3 V2740	<input type="checkbox"/> PGX V2799-SV V2799-BI
L			<input type="checkbox"/> Frame Enclosed <input type="checkbox"/> New Frame <input type="checkbox"/> Used Frame				
Frame Manufacturer	Frame Style	Eye Size	Bridge Size	Temple	Color		
Add Ons (VER REQUIRED)						Special Instructions: (Include medical justification for tint and/or special instructions for lab)	
<input type="checkbox"/> VIP X/L Progressives V2781 <input type="checkbox"/> Scratch Resist V2760 <input type="checkbox"/> Spectralite S0590-SV/S0590-BI <input type="checkbox"/> Multi-Layer Anti-Glare V2750 <input type="checkbox"/> Plastic Photochromic V2744 <input type="checkbox"/> 1.60 S0581-SV/S0581-BI <input type="checkbox"/> Polycarbonate S0580-SV/S0580-BI <input type="checkbox"/> Other: _____							
* Do not send case, straps, or specialty attachments with frame(s)							
PROFESSIONAL SIGNATURE:			DATE OF SERVICE:		TELEPHONE: ()		
Lab Copy Lab Billing Copy Packing Slip/Mailing Label Doctor's Copy			SHIP TO:				



INLAND EMPIRE HEALTH PLAN

PCP VISION REPORT

TO BE COMPLETED BY THE VISION PROVIDER

Member's Name: _____ Exam Date: _____
 Member's IEHP ID#: _____ DOB: _____

CHECK HERE IF MEMBER WAS REFERRED BY THE PCP

FROM:

Vision Provider: _____ Phone: _____
 Address: _____ City: _____ Zip: _____

TO:

Forwarded by: MAIL FAX

PCP: _____ Phone: _____
 Address: _____ City: _____ Zip: _____
 Phone: _____ Fax: _____

EXAMINATION FINDINGS

CHECK ALL THAT APPLY:

- This was a dilated **Diabetic Retinal Examination (DRE)** using a binocular indirect ophthalmoscope to rule out diabetic eye disease. Examination results are as follows:
 - Normal Findings
 - Other (please complete section below)
- This was a medical eye visit for evaluation, treatment and management of an acute ocular condition: (please complete section below)

Symptoms (detail): _____

Diagnosis: _____ ICD Code: _____

Procedures / Treatment Plan: _____

Recommendations: _____

Vision Provider: _____ Date: _____ Next Visit: _____
 (signature)

NOTICE:

This facsimile contains confidential information that is being transmitted to and is intended only for the 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 (909) 890-2054.

**OPHTHALMOLOGIST
REFERRAL FORM**



DATE: _____

1A. OPTOMETRY TO OPHTHALMOLOGY REFERRALS ONLY

1. Fax a copy to the Member's IPA.
2. Place a copy in Member's medical record.
3. Fax a final copy back to the referring Optometrist

1B. REFERRAL TYPE

GENERAL OPHTHALMOLOGY

RETINA SPECIALIST

PEDIATRIC OPHTHALMOLOGY

MEDICALLY URGENT

ROUTINE – Decision in five (5) working days

Patient Request

2. GENERAL INFORMATION

Member Name (please print)		DOB	ID #
Plan (select one)	<input type="checkbox"/> Medi-Cal <input type="checkbox"/> DualChoice	<input type="checkbox"/> Healthy Kids	Parent/Guardian/Caretaker name (REQUIRED)
Address	City	Zip	Phone
Diagnosis	ICD-9 Code (REQUIRED)		

Clinical justification for referral (and description of procedure requested if any) *REQUIRED

Referring Provider (please print)	Phone	Fax
Address	City	Zip
Referring Provider Signature (REQUIRED)	Office Contact Person	

3. COMPLETED BY IPA

Ophthalmologist Referred (please print)	Appointment Date	Phone
Address	City	Zip
<input type="checkbox"/> Office <input type="checkbox"/> Outpatient	CPT Code (REQUIRED)	
Date Additional Information Requested:	Date Additional Information Received:	<input type="checkbox"/> Approved <input type="checkbox"/> Modified <input type="checkbox"/> Denied

Medical Reviewer Comments

IF YOU WOULD LIKE TO DISCUSS THIS DECISION WITH THE PHYSICIAN REVIEWER, PLEASE CONTACT THE IPA:

IPA NAME: _____ **Phone:** () -

Medical Reviewer Signature (Circle Title: MD, DO, OD, RN, LVN, Coordinator)	Date/Time	Criteria utilized in making this decision are available upon request by calling IEHP – Provider Relations at (909) 890-2054.
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UPON ACCEPTANCE OF REFERRAL AND TREATMENT OF THE MEMBER, THE PHYSICIAN/PROVIDER AGREES TO ACCEPT IPA 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.

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FAX COMPLETED REFERRAL FORMS TO THE MEMBER'S IPA.



NON-COVERED SERVICES / MATERIALS WAIVER FORM

MEMBER NAME: _____ MEMBER DOB: _____

MEMBER IEHP ID#: _____

PROVIDER NAME: _____

Requested Non-Covered Service(s) and/or Materials (check all that apply):

- | | FEE |
|---|----------|
| <input type="checkbox"/> Cosmetic contact lenses and fitting services | \$ _____ |
| <input type="checkbox"/> Non-benefit frames | \$ _____ |
| <input type="checkbox"/> Cosmetic tints/lens coatings | \$ _____ |
| <input type="checkbox"/> Lenses, other than CR39 and Glass | \$ _____ |
| <input type="checkbox"/> Other _____
(specify) | \$ _____ |

Total Charges: \$ _____

I request the specified service(s)/materials. I understand that the service(s)/materials are not covered by IEHP and/or Medi-Cal and are unavailable as a benefit to me. I understand that I am under no obligation to purchase any non-covered service or that in requesting such services or materials, I accept full responsibility of payment for all charges as indicated above.

This waiver does not apply to any IEHP/Medi-Cal covered benefits. All standards regarding covered benefits are unaffected by the provisions of this waiver.

Member's Signature

Date

Provider's Signature

Date



FORMULARIO DE EXENCIÓN DE SERVICIOS/MATERIALES SIN COBERTURA

NOMBRE DEL MIEMBRO: _____

FECHA DE NACIMIENTO DEL MIEMBRO: _____

DE IDENTIFICACIÓN DE IEHP DEL MIEMBRO: _____

NOMBRE DEL PROVEEDOR: _____

Servicio(s) y/o materiales sin cobertura solicitado(s) (marcar todas las opciones que correspondan):

TARIFA

- Lentes de contacto cosméticos y servicios de ajuste \$ _____
- Armazones que no forman parte de sus beneficios \$ _____
- Tintes cosméticos/recubrimientos para lentes \$ _____
- Lentes, que no sean de CR39 ni de vidrio \$ _____
- Otros _____ \$ _____
(especifique)

Importe total: \$ _____

Solicito el servicio(s)/material(es) especificado(s). Comprendo que el servicio(s)/material(es) no está cubierto por IEHP y/o por Medi-Cal y que no están disponibles para mí como un beneficio. Comprendo que no estoy obligado a adquirir ningún servicio sin cobertura y que, al solicitar dichos servicios o materiales, acepto la responsabilidad total del pago de todos los importes indicados arriba.

Esta exención no se aplica a ninguno de los beneficios cubiertos de IEHP/Medi-Cal. Ninguno de los estándares relacionados con los beneficios cubiertos se verá afectado por las disposiciones de esta exención.

Firma del miembro

Fecha

Firma del proveedor

Fecha

**INLAND EMPIRE HEALTH PLAN
IEHP Medicare DualChoice HMO SNP**

ASTHMA HEALTH MANAGEMENT PROGRAM

INTRODUCTION

The Asthma Health Management Program is designed to serve as a resource and to support both Members and practitioners as follows:

- Assist in the management of Members with identified high-risk factors by providing education, assessments, and other services as necessary;
- Enhance Members' ability to self-monitor and report potential changes in their condition;
- Utilize the initial health risk assessment (HRA) or the Asthma survey to assess multiple areas including medical, behavioral, depression, psychosocial, socio-economic, cognitive, lifestyle, and functional needs of the targeted population;
- Use the results of the HRA and the disease specific surveys as a foundation to develop an individualized care plan and refer to the appropriate health care professionals or practitioners to provide care. Completed care plans are sent to the practitioners via fax and are posted on the provider web portal. Members may receive a copy upon request;
- Use completed care plans to communicate members' health status with practitioners and to educate Members on nutrition, healthy lifestyle, risk factors, signs and symptoms of the medical conditions, the importance of adherence to medical treatments and medications;
- With Member's consent, provide information about the Member's condition to Member's caregivers, legal guardianship, or conservatorship;
- Evaluate Members who are referred to the Asthma Program from internal and external resources or agencies, (e.g. hospital, home health agency, or Inpatient Review Nurses);
- Promote optimal patient/physician interactions and encourage Members to communicate with their practitioners about their health condition and medical treatment;
- Provide feedback to enhance care management and improve Members' understanding of their health condition or health maintenance;
- Encourage adherence to practitioner treatment plans including medication use, obtaining preventive services, attending Asthma Classes, lifestyle modifications and referrals to external agencies and resources;
- Determine the level of interventions based on the Members' health risk factors. Levels of interventions range from annual mailing of educational materials to in-depth telephonic interactions as frequently as needed;

- Use electronic health records and maxMC, a medical management system, to store and integrate Members' information from various systems to facilitate access to Member health information for continuity of care, i.e. utilization management data, care management, disease program line, nurse advice line, wellness programs, and other relevant clinical information; and
- Perform quality improvement activities including measuring the effectiveness of disease specific program, monitoring and measuring active Member participation rates at least annually.

CLINICAL PRACTICE GUIDELINES

IEHP has established clinical practice guidelines for the Asthma Management Program that serve as the basis for Program activities.

- Guidelines are reviewed and approved by board-certified practitioners in the appropriate specialties and are based on The Expert Panel II: Guidelines for the Diagnosis and Management of Asthma, and National Heart, Lung and Blood Institute (NHLBI) recommendations.
- Guidelines are redistributed as they are revised and/or updated.
- Guidelines can be reviewed online at iehp.org or by contacting the IEHP HM unit at (866) 224-4347 for a paper copy.

GRIEVANCE/APPEAL PROCESS

IEHP maintains a formal grievance and appeal resolution system for all Members and practitioners in order to acknowledge, address, and resolve all grievances and appeals in a timely manner. All Asthma Program Members have access to this grievance and appeal resolution system and are given information in the Member Handbook on how to access the system to register complaints, grievances and appeals. Practitioners have access to IEHP's provider resolution process and information is available in the IEHP Policy and Procedure Manual. Practitioners may submit grievances in writing to IEHP-Provider Services at P.O. Box 19026, San Bernardino, CA 92423, or contact IEHP's Provider Relations Team at (909) 890-2054 for assistance.

CONFIDENTIALITY

IEHP has established stringent confidentiality standards governing the use and disclosure of protected health information and for protecting personal medical information. Confidentiality policies address Member medical records, database information, discussions with Members and practitioners, written communications, and other confidential information. For further information or assistance, contact IEHP's Provider Relations Team at (909) 890-2054.

ACCESS TO PROGRAM SERVICES

Clinical and emergent care for asthmatic Members will continue to be provided at the direction of the Member's PCP. IEHP provides convenient access to its Asthma Program for practitioners and Members as follows:

Routine Telephone Access to IEHP Member Services Staff:

- Available Monday through Friday, from 8:00 AM to 5:00 PM;
- Toll free number, **(800) 440-4347**.

Asthma Program Telephone Access, Urgent and Non-urgent:

- Members at higher risk that are enrolled in the Asthma Program may also be assigned to a Care Manager and provided with a direct toll-free number, **(866) 224-4347**, to call for both urgent and non-urgent assistance during regular hours of operation.
- At the time Members are given the phone number, they are instructed to first call their PCP in the event of an emergency. IEHP does not direct clinical care.
- Members calling with emergent needs are instructed to seek immediate emergency services.
- Members calling from a rotary phone, during normal hours of operation, are given directions on how to reach a live person.

Practitioner Access to Asthma Program Staff:

- Practitioners are provided with a toll-free direct number, **(866) 224-4347**, to call and speak with Asthma Program staff during regular hours of operation, Monday – Friday 8-5.

After Hours Access:

- After hours access is provided through a toll free OnCall Advice Line, **(866) 244-4347**, that is staffed by trained RNs.
- Trained health care professionals give Program Members information and direct them to care as clinically appropriate.

ORGANIZATIONAL STRUCTURE/STAFFING

Nurse Care Managers and Wellness Coordinators report to the Model of Care Nurse Manager. The overall direction and oversight of the Program is the responsibility of the Chief Medical Officer.

MEMBERS' RIGHTS AND RESPONSIBILITIES

- All IEHP Members receive a Member Handbook that delineates Members' Rights and Responsibilities
- Members have the right to open communication with practitioners regarding treatment options regardless of cost or benefits.
- Members also have the right to refuse participation or opt out of HM Programs.

PROGRAM ELIGIBILITY AND INITIAL RISK STRATIFICATION

- All asthmatic Members are eligible for enrollment into the Asthma Program. Members are then assessed for risk factors and stratified into one of three risk levels based on utilization of medication, hospitalization, pharmacy data, laboratory results,

health risk assessment survey, Asthma survey, claim or encounter data, UM process, case management process, ED encounters, electronic health records, Member and Practitioner referrals.

- Program participation is defined by a passive methodology. The passive participation rate is calculated as the number of eligible Members who do not actively opt out of the Program. All eligible Members are initially contacted and offered services and given the opportunity to actively opt out.

INTERVENTIONS BY STRATIFICATION

- **Level I** – All Members receive an initial packet that includes a brochure, an invitation to attend asthma classes, information on the Asthma Program, and a direct toll-free number to call for assistance. Annually a letter is sent to remind the Member of services available to them.
- **Level II** – Members receive the initial packet followed by an intake survey assessment. Once the intake survey is received, it is entered into the maxMC database by a Wellness Coordinator and/or Care Manager to gather additional information about clinical and functional status, risk factors, psychosocial issues, disease knowledge and special needs such as language barriers, vision and hearing deficits. Additional interventions include: Nurse review, Individual Care Plan (ICP), provider notification letter, ongoing telephonic monitoring, at least every six (6) months, by Wellness Coordinators, or Care Manager, medication review, and referrals to specialists and/or community resources based on the specific clinical and psychosocial needs of the Member.
- **Level III** – Members receive all Level II interventions. A comprehensive intake assessment is performed telephonically by a Care Manager and/or Wellness Coordinators. The Care Manager develops an Individual Care Plan (ICP). These Members receive additional ongoing telephonic monitoring and assessments at a minimum of once every three (3) months and more often as appropriate. Home visits may be conducted to better assess the home environment, functional and clinical status and provide an opportunity for one-on-one education.

RE-STRATIFICATION

Members are reassessed for risk factors and re-stratified at least monthly. New information from encounter and pharmacy data, referrals, after-hours Member calls and other patient contact information is added to the HM database daily and serve as concurrent re-stratification opportunities. The re-stratification criteria are based on identification of additional risk factors.

DEVELOPMENT OF INDIVIDUAL CARE PLAN

Individual Care Plans are developed for all Members identified as a Level II or III risk. Development of a Member's Individual Care Plan is based on data provided from the practitioner, telephonic assessment, ongoing monitoring activities, and discussion with the Member and/or family members as appropriate. Care Plans are initially sent to the

Member and PCP and as they are updated. Care plans are discussed telephonically with the Member and a care plan summary is available to the Member upon request.

PRACTITIONER RIGHTS

IEHP informs practitioners regarding their rights as primary caregivers for Program Members. Please refer to Policy 22B, "Practitioners' Rights and Responsibilities".

PRACTITIONER COMMUNICATIONS

- Practitioners receive quarterly mailings of lists of all their Members eligible for the Program.
- Practitioners are sent letters regarding their individual Members participating in the Program following the initial assessment process. The letter contains information about the Member's assigned risk level and when to expect future communication.
- Practitioners are additionally communicated with via fax or phone with information regarding individual Member's status subsequent to staff discussions/interactions with the Member or Member encounters.
- Urgent Information – Urgent information is communicated to practitioners through telephone or fax within one business day depending on the clinical urgency of the situation.
- Physician comparison reports are mailed to Practitioners yearly. This report allows Physicians to compare how you relate amongst your peers in the care of your asthmatic members.

FEEDBACK

IEHP gathers information from practitioners regarding the usefulness of services available through the Asthma Program, the usefulness of decision support materials, and the helpfulness of the staff providing services. Practitioners may provide feedback regarding the Health Management Program through direct contact with HM Staff, grievances or written communications. Practitioner input is utilized to strengthen the program and improve communications and interventions. Feedback from Members, including grievance and appeal data related to the Program, and Satisfaction Surveys is collected and analyzed to identify opportunities for enhancing Program operations and effectiveness. The data is analyzed annually and used to improve program content and operations.

**INLAND EMPIRE HEALTH PLAN
IEHP Medicare DualChoice HMO SNP**

DIABETES HEALTH MANAGEMENT PROGRAM

INTRODUCTION

The Diabetes Health Management Program is designed to serve as a resource and to support both Members and practitioners as follows:

- Assist in the management of Members with identified high-risk factors by providing education, assessments, and other services as necessary;
- Enhance Members' ability to self-monitor and report potential changes in their condition;
- Utilize the initial health risk assessment (HRA) or the Diabetes survey to assess multiple areas including medical, behavioral, depression, psychosocial, socio-economic, cognitive, lifestyle, and functional needs of the targeted population;
- Use the results of the HRA and the diseases specific surveys as a foundation to develop an individualized care plan and refer to the appropriate health care professionals or practitioners to provide care. Completed care plans are sent to the practitioners via fax and are posted on the provider web portal. Members may receive a copy upon request;
- Using completed care plans to communicate Members' health status with practitioners and to educate Members on nutrition, healthy lifestyle, risk factors, signs and symptoms of the medical conditions, the importance of adherence to medical treatments and medications;
- With Member's consent, provide information about the Member's condition to Member's caregivers, legal guardianship, or conservatorship;
- Evaluate Members who are referred to the Diabetes Program from internal and external resources or agencies, (e.g. hospital, home health agency, or Inpatient Review Nurses);
- Promote optimal patient/physician interactions and encourage Members to communicate with their practitioners about their health condition and medical treatment;
- Provide feedback to enhance care management and improve Members' understanding of their medical condition or health maintenance;
- Encourage adherence to practitioner treatment plans including medication use, obtaining preventive services, attending Diabetes Classes, lifestyle modifications and referrals to external agencies and resources;
- Determine the level of interventions based on Members' health risk factors. Levels of interventions range from annual mailing of educational materials to in-depth telephonic interactions as frequently as needed;
- Use electronic health records and maxMC, a medical management system, to store and integrate Members' information from various systems to facilitate access to Member health information for continuity of care, i.e. utilization management data, care management,

disease program line, nurse advice line, wellness program, and other relevant clinical information;

- Perform quality improvement activities including measuring the effectiveness of disease specific program, monitoring and measuring active Member participation rates at least annually.

CLINICAL PRACTICE GUIDELINES

IEHP has established clinical practice guidelines for the Diabetes Management Program that serve as a basis for Program activities.

- Guidelines are reviewed and approved by board-certified practitioners in the appropriate specialties and are based on the current American Diabetes Association (ADA) recommendations.
- Guidelines are redistributed as they are revised and/or updated.
- Guidelines can be reviewed online at iehp.org or by contacting the IEHP HM unit at (866) 244-4347 for a paper copy.

GRIEVANCE/APPEAL PROCESS

IEHP maintains a formal grievance and appeal resolution system for all Members and practitioners in order to acknowledge, address, and resolve all grievances and appeals in a timely manner. All Diabetes Program Members have access to this grievance and appeal resolution system and are given information in the Member Handbook on how to access the system to register complaints, grievances and appeals. Practitioners have access to IEHP's provider resolution process and information is available in the IEHP Policy and Procedure Manual. Practitioners may submit grievances in writing to IEHP-Provider Services at P.O. Box 19026, San Bernardino, CA 92423, or contact IEHP's Provider Relations Team at (909) 890-2054 for assistance.

CONFIDENTIALITY

IEHP has established stringent confidentiality standards governing the use and disclosure of protected health information and for protecting personal medical information. Confidentiality policies address Member medical records, database information, discussions with Members and practitioners, written communications, and other confidential information. For further information or assistance, contact IEHP's Provider Relations Team at (909) 890-2054.

ACCESS TO PROGRAM SERVICES

Clinical and emergent care for diabetic Members will continue to be provided at the direction of the Member's PCP. IEHP provides convenient access to its Diabetes Program for practitioners and Members as follows:

Routine Telephone Access to IEHP Member Services Staff:

- Available Monday through Friday, from 8:00 AM to 5:00 PM;
- Toll free number, **(800) 440-4347**.

Diabetes Program Telephone Access, Urgent and Non-urgent:

- Members at higher risk that are enrolled in the Diabetes Program may also be assigned to a Care Manager and provided with a direct toll-free number, **(866) 224-4347** to call for both urgent and non-urgent assistance during regular hours of operation.
- At the time Members are given the phone number, they are instructed to first call their PCP in the event of an emergency. IEHP does not direct clinical care.
- Members calling with emergent needs are instructed to seek immediate emergency services.
- Members calling from a rotary phone, during normal hours of operation, are given directions on how to reach a live person.

Practitioner Access to Diabetes Program Staff:

- Practitioners are provided with a toll-free direct number, **(866) 224-4347**, to call and speak with Diabetes Program staff during regular hours of operation, Monday – Friday, 8-5.

After Hours Access:

- After hours access is provided through a toll free OnCall Advice Line, **(866) 244-4347**, that is staffed by trained RNs.
- Trained health care professionals give Program Members information and direct them to care as clinically appropriate.

ORGANIZATIONAL STRUCTURE/STAFFING

Nurse Care Managers and Wellness Coordinators report to the Model of Care Nurse Manager. The overall direction and oversight of the Program is the responsibility of the Chief Medical Officer.

MEMBERS' RIGHTS AND RESPONSIBILITIES

- All IEHP Members receive a Member Handbook that delineates Members' Rights and Responsibilities
- Members have the right to open communication with practitioners regarding treatment options regardless of cost or benefits.

- Members also have the right to refuse participation or opt out of HM Programs.

PROGRAM ELIGIBILITY AND INITIAL RISK STRATIFICATION

- All diabetic Members are eligible for enrollment into the Diabetes Program. Members are then assessed for risk factors and stratified into one of three risk levels based on utilization of medication, hospitalization, pharmacy data, laboratory results, health risk assessment survey, Diabetes survey, claim or encounter data, UM process, case management process, ED encounters, electronic health records, Member and practitioner referrals.
- Program participation is defined by a passive methodology. The passive participation rate is calculated as the number of eligible Members who do not actively opt out of the Program. All eligible Members are initially contacted and offered services and given the opportunity to actively opt out.

INTERVENTIONS BY STRATIFICATION

- **Level I** – All Members receive an initial packet that includes a brochure, an invitation to attend diabetes classes, information on the Diabetes Management Program, and a direct toll-free number to call for assistance. Annually a letter is sent to remind the Member of the services available to them.
- **Level II** – Members receive the initial packet followed by an intake survey assessment. Once the intake survey is received, it is entered into maxMC database by a Wellness Coordinator and/or Care Manager to gather additional information about clinical and functional status, risk factors, psychosocial issues, disease knowledge and special needs such as language barriers, vision and hearing deficits. Additional interventions include: Nurse review, Individual Care Plan (ICP), provider notification letter, ongoing telephonic monitoring at least every 6 months by Wellness Coordinator and/or Care Manager, reminders about screening and testing, medication review, and referrals to specialists and/or community resources based on the specific clinical and psychosocial needs of the Member.
- **Level III** – Members receive all Level II interventions. A comprehensive intake assessment is performed telephonically by a Care Manager and an Individual Care Plan (ICP) is developed. These Members receive additional ongoing (monthly) telephonic monitoring and assessments at a minimum of once every three (3) months and more often as appropriate. Home visits may be coordinated to better assess the home environment, functional and clinical status and provide an opportunity for one-on-one education.

RE-STRATIFICATION

Members are reassessed for risk factors and re-stratified at least monthly. New information from encounter and pharmacy data, referrals, after hours Member calls and other patient contact information is added to the HM database daily and serve as concurrent re-stratification opportunities. The re-stratification criteria are based on identification of additional risk factors.

DEVELOPMENT OF INDIVIDUAL CARE PLAN

Individual Care Plans are developed for all Members identified as a Level II or III risk. Development of a Member's individual Care Plan is based on data provided from the practitioner, telephonic assessment, ongoing monitoring activities, and discussion with the Member and/or family members as appropriate. Care Plans are sent to the PCP initially and as they are updated. Care plans are discussed telephonically with the Member and a care plan summary is available to be mailed to the Member upon request.

PRACTITIONER RIGHTS

IEHP informs practitioners regarding their rights as primary caregivers for Program Members. Please refer to Policy 22B, "Practitioners' Rights and Responsibilities".

PRACTITIONER COMMUNICATIONS

- Practitioners receive quarterly mailing of lists of all their Members eligible for the Program.
- Practitioners are sent letters regarding their individual Members participating in the Program following the initial assessment process. The letter contains information about the Member's assigned risk level and when to expect future communication.
- Practitioners are additionally communicated with via fax or phone with information regarding individual Member's status subsequent to staff discussions/interactions with the Member or Member encounters.
- Urgent Information – Urgent information is communicated to practitioners through telephone or fax within one business day depending on the clinical urgency of the situation.

Physician comparison reports are mailed to Practitioners yearly. This report allows Physicians to compare how you relate amongst your peers in the care of your diabetic members.

FEEDBACK

IEHP gathers information from practitioners regarding the usefulness of services available through the Diabetes Program, the usefulness of decision support materials, and the helpfulness of the staff providing services. Practitioners may provide feedback regarding the Health Management Program through direct contact with HM Staff, grievances or written communications. Practitioner input is utilized to strengthen the program and improve communications and interventions. Feedback from Members, including grievance and appeal data related to the Program, and Satisfaction Surveys is collected and analyzed to identify opportunities for enhancing Program operations and effectiveness. The data is analyzed annually and used to improve program content and operations.

**INLAND EMPIRE HEALTH PLAN
IEHP Medicare DualChoice HMO SNP**

HIGH RISK OBSTETRIC PROGRAM

INTRODUCTION

The High Risk Obstetric (HROB) Program is designed to serve as a resource and to support to both Members and practitioners as follows:

- Assist in the management of Members with identified high-risk factors by providing education, assessments, and other services as necessary;
- Enhance Members' ability to self-monitor and report potential changes in their condition;
- Utilize the initial health risk assessment (HRA) or the High Risk Obstetric survey to assess multiple areas including medical, behavioral, depression, psychosocial, socio-economic, cognitive, lifestyle, and functional needs of the targeted population;
- Use the results of the HRA and the disease specific surveys as a foundation to develop an individualized care plan and refer to the appropriate health care professionals or practitioners to provide care. Completed care plans are sent to the practitioners via fax and are posted on the provider web portal. Members may receive a copy upon request;
- Use completed care plans to communicate Members' health status with practitioners and to educate Members on nutrition, healthy lifestyle, risk factors, signs and symptoms of the medical conditions, the importance of adherence to medical treatments and medications;
- With Member's consent, provide information about the Member's condition to Member's caregivers, legal guardianship, or conservatorship;
- Evaluate Members who are referred to the High Risk Obstetric Program from internal and external resources or agencies, (e.g. hospital, home health agency, or Inpatient Review Nurses);
- Promote optimal patient/physician interactions and encourage Members to communicate with their practitioners about their health condition and medical treatment;
- Provide feedback to enhance care management and improve Members' understanding of their medical condition or health maintenance;
- Encourage adherence to practitioner treatment plans including medication use, obtaining preventive services, attending prenatal and postpartum appointments, nutrition, lifestyle modifications and referrals to external agencies and resources;
- Determine the level of interventions based on the Members' health risk factors. Levels of interventions range from annual mailing of educational materials to in-depth telephonic interactions as frequently as needed;
- Use electronic health records and maxMC, a medical management system, to store and integrate Members' information from various systems to facilitate access to Member health information for continuity of care, i.e. utilization management data, care management,

disease program line, nurse advice line, wellness programs, and other relevant clinical information; and

- Perform quality improvement activities including measuring the effectiveness of disease specific program, monitoring and measuring active Member participation rates at least annually.

CLINICAL PRACTICE GUIDELINES

IEHP has established clinical practice guidelines for the HROB Program that serve as the basis for Program activities.

- Guidelines are reviewed and approved by board-certified Obstetricians and are based on current American College of Obstetricians and Gynecologists (ACOG) recommendations.
- Guidelines are re-distributed as they are revised and/or updated.
- Guidelines can be reviewed online at iehp.org or by contacting the HM Unit at (866) 224-4347 for a paper copy.

GRIEVANCE/APPEAL PROCESS

IEHP maintains a formal grievance and appeal resolution system for all Members in order to acknowledge, address, and resolve all grievances and appeals in a timely manner. All HROB Program Members have access to this grievance and appeal resolution system and are given information in the Member Handbook on how to access the system to register complaints, grievances and appeals. Practitioners have access to IEHP's provider resolution process and information is available in the IEHP Policy and Procedure Manual. Practitioners may submit grievances in writing to IEHP-Provider Services at P.O. Box 19026, San Bernardino, CA 92423, or contact IEHP's Provider Relations Team at (909) 890-2054 for assistance.

CONFIDENTIALITY

IEHP has established stringent confidentiality standards governing the use and disclosure of protected health information and for protecting personal medical information. Confidentiality policies address Member medical records, database information, discussions with Members and practitioners, written communications, and other confidential information. For further information or assistance, contact IEHP's Provider Relations Team at (909) 890-2054.

ACCESS TO PROGRAM SERVICES

Clinical and emergent care for pregnant Members will continue to be provided at the direction of the obstetric practitioner. IEHP provides convenient access to its HROB Program for practitioners and Members as follows:

Routine Telephone Access to IEHP Member Services Staff:

- Available Monday through Friday, from 8:00 AM to 5:00 PM;

- Toll free number, **(800) 440-4347**.

HROB Program Telephone Access, Urgent and Non-urgent:

- Members at higher risk that are enrolled in the HROB Program may also be assigned to a Perinatal Care Manager and provided with a direct toll-free number, **(866) 224-4347**, to call for both urgent and non-urgent assistance during regular hours of operation.
- At the time Members are given the phone number, they are instructed to first call their obstetric practitioner in the event of an emergency. IEHP does not direct clinical care.
- Members calling with emergent needs are instructed to seek immediate emergency services.
- Members calling from a rotary phone, during normal hours of operation, are given directions on how to reach a live person.

Practitioner Access to HROB Program Staff:

- Practitioners are provided with a toll free direct number, **(866) 224-4347**, to call and speak with HROB Program staff during regular hours of operation, Monday – Friday, 8-5.

After Hours Access:

- After hours access is provided through a toll free OnCall Advice Line, **(866) 244-4347**, that is staffed by trained RNs.
- Trained health care professionals give Program Members information and direct them to care as clinically appropriate.

ORGANIZATIONAL STRUCTURE/STAFFING

Nurse Care Managers and Wellness Coordinators report to the Model of Care Nurse Manager. The overall direction and oversight of the Program is the responsibility of the Chief Medical Officer.

MEMBERS' RIGHTS AND RESPONSIBILITIES

- All IEHP Members receive a Member Handbook that delineates Members' Rights and Responsibilities
- Members have the right to open communication with practitioners regarding treatment options regardless of cost or benefits.
- Members also have the right to refuse participation or opt out of HM Programs.

PROGRAM ELIGIBILITY AND INITIAL RISK STRATIFICATION

- All pregnant women are eligible for enrollment into the HROB Program. Members are then assessed for risk factors and stratified into one of three risk levels with confirmation by the Perinatal Care Manager.
- IEHP has multiple avenues on how to identify pregnant Members into the High Risk

Obstetric program. These include but are not limited to the following data sources:

- Claims or encounter data
 - Pharmacy data
 - Health risk assessment
 - HROB Survey
 - Laboratory results
 - Data collected through the UM and CM processes
 - Wellness program
 - Electronic Health Records
 - Member and practitioner referrals
- Program participation is defined by a passive methodology. The passive participation rate is calculated as the number of eligible Members who do not actively opt out of the Program.

INTERVENTIONS BY STRATIFICATION

- **All Members** – All Members receive an initial prenatal packet that includes a brochure, information on the HROB Program, and a direct toll-free number to call for assistance, and an intake survey assessment. Once the intake survey is received, it is entered into maxMC database by a Wellness Coordinator or Nurse Care Manager to gather additional information about risk factors, psychosocial issues and special needs such as language barriers, vision and hearing deficits from there the care manager places them in the appropriate level.
- **Level I** – Members receive the initial packet . Additional interventions include: RN Care Management review, provider notification, telephonic reassessments at least once per trimester by Wellness Coordinators, or care manager, mailings of condition specific brochures, nutritional counseling and provision of referrals to classes, and community/county/state resources based on the specific clinical and psychosocial needs of the Member. Members are contacted based on their individual needs identified during these assessments and from other Member contacts or encounters.
- **Level II** – Members receive all Level I interventions plus an Individual Care Plan (ICP), a staff review of their medical records and additional ongoing telephonic monitoring and assessments at a minimum of once every 60 days and more often based on their individual needs until 8 week postpartum.
- **Level III** – Members receive all Level II interventions. Members receive telephone follow-up at intervals based on risk factors and discussions with the Member and/or the practitioner at a minimum of once every 45 days. Home visits by VNA nurses may be scheduled during the pregnancy or upon delivery (postpartum visit) if indicated. Additional interventions include ongoing telephonic monitoring by the Perinatal Care Manager and/or a Wellness Coordinator as dictated by the Member's Care Plan and individual condition and circumstances. Frequency of additional contact is dictated by Member need and information from assessments, discussions and encounters.

RE-STRATIFICATION

Members are reassessed for risk factors and re-stratified at least once per trimester. New information from encounter data, pharmacy, and Pregnancy Notification/Outcomes (PNO) forms and perinatal risk assessments is added to the HM database daily and serve as concurrent re-stratification opportunities. The re-stratification criteria are based on identification of additional risk factors.

DEVELOPMENT OF INDIVIDUAL CARE PLAN

Individual Care Plans are developed for all Members identified as a Level II or III risk. Development of a Member's Individual Care Plan is based on data provided from the practitioner, telephonic assessment, ongoing monitoring activities, feedback from referral sources, and discussion with the Member and/or family members as appropriate. Care Plans are discussed with the Member, sent to the Provider initially and as they are updated. A care plan summary is available to the Member upon request.

PRACTITIONER RIGHTS

IEHP informs practitioners regarding their rights as primary caregivers for Program Members. Please refer to Policy 22B, "Practitioners' Rights and Responsibilities".

PRACTITIONER COMMUNICATIONS

- Practitioners receive quarterly mailings of lists of all their Members eligible for the Program.
- Practitioners are sent letters regarding their individual Members participating in the Program following the initial assessment process. The letter contains information about the Member's assigned risk level and when to expect future communication.
- Practitioners are additionally communicated with via fax or phone with information regarding individual Member's status subsequent to staff discussions/interactions with the Member or Member encounters.
- Urgent Information – Urgent information is communicated to practitioners through telephone or fax within one business day depending on the clinical urgency of the situation.
- Physician comparison reports are mailed to Practitioners yearly. This report allows Physicians to compare how you relate amongst your peers in the care of your Pregnant Members.

FEEDBACK

IEHP gathers information from practitioners regarding the usefulness of services available under the HROB Program, the usefulness of decision support materials, and the helpfulness of the staff providing services. Practitioners may provide feedback regarding the Health Management

Program through direct contact with HM Staff, grievances or written communications. Practitioner input is utilized to strengthen the program and improve communications and interventions. Feedback from Members, including grievance and appeal data related to the Program, and Satisfaction Surveys, is collected and analyzed to identify opportunities for enhancing Program operations and effectiveness. The data is analyzed annually and used to improve program content and operations.