14. UTILIZATION MANAGEMENT

A. Utilization Management Delegation and Monitoring

APPLIES TO:

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

POLICY:

A. IEHP is responsible for the development, implementation, and distribution of standards for Utilization Management (UM) processes and activities.

B. IEHP is responsible for maintaining a monitoring system for UM Program oversight.

C. The IEHP UM Subcommittee is responsible for performing an evaluation of UM Program objectives and progress on an annual basis with modifications, as directed by the Quality Management (QM) Committee and IEHP Governing Board.

D. Practitioners and employees/staff who make utilization-related decisions are responsible for identifying barriers to care, instances of under/over utilization of services, and assisting with appropriate use of services.

E. Members are not discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, medical history, claims history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source payment.

F. There must be a Second Opinion process in place for Members requesting second opinions and a tracking mechanism for these requests (see Attachment 14-4 in Section 14, "Attachments").

G. Provider or Member appeals of UM decisions are handled through the IEHP Provider or Member Appeal and Grievance Process. Please refer to Section 16, "Grievance Resolution System" for more information on Provider and Member grievances.

PROCEDURE:

A. **UM Standards**: IEHP is responsible for defining overall standards for UM activities. These standards represent the minimum performance level acceptable to IEHP.

B. **Criteria:** Nationally recognized UM standards must be used when making decisions related to medical care. Criteria sets approved by IEHP include: Center for Medicare and Medicaid Services (CMS), IEHP UM Subcommittee Approved Authorization Guidelines, Milliman Care Guidelines, InterQual, and Apollo Managed Care Guidelines/Medical Review Criteria.

   1. **Development:** Criteria or guidelines that are developed by IEHP and used to determine whether to authorize, modify, or deny health care services are developed with involvement from actively practicing health care practitioners.

The criteria or guidelines must be consistent with sound clinical principles and processes and must be evaluated, and updated if necessary, at least annually.

2. **Application:** Criteria must be applied in a consistent and appropriate manner based on available medical information and the needs of individual Members. To ensure consistent application of UM Criteria follow this specific order:

   a. Check the CMS guideline.

   b. Check if there is an approved IEHP UM Subcommittee guideline to reference.

   c. Check evidence based criteria such as Milliman or InterQual.

   d. Check Apollo Medical Reeview Criteria.

   When applying criteria, individual factors such as age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment are taken into consideration. Additionally, criteria applied takes into consideration the issues of whether services are available within the service area, benefit coverage, and other factors that may impact the ability to implement an individual Member's care plan. The organization also considers characteristics of the local delivery system available for specific patients, such as:

   a. Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge;

   b. Coverage of benefits for skilled nursing facilities, subacute care facilities or home care where needed; and

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

3. **Annual Review and Adoption of Criteria:** Members of the UM Subcommittee and practitioners in the appropriate specialty, review criteria annually and update as necessary. New criteria that become available prior to the annual evaluation are reviewed by IEHP's Chief Medical Officer (CMO) and Medical Director and are presented to the IEHP UM Subcommittee for discussion, research, and refinement. Criteria approved by IEHP's UM Subcommittee are presented to the QM Committee for adoption and implementation. Once IEHP's UM or QM Committee has approved the criteria and updates, the information is disseminated to providers via letter, email, or site visits.

4. **Process for Obtaining Criteria:** The clinical guidelines or criteria used for determining health care services specific to the procedure or condition must be disclosed to network practitioners, Members, or the public, upon request.

Member letters must state the address and/or phone number for obtaining the utilization criteria or benefits provision used in the decision. The following notice must accompany every disclosure of information: "The materials provided to you are guidelines used by the plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your health plan" (see Attachment 14-1a in Section 14, "Attachments"). A log must be maintained of all requests for criteria (see Attachment 14-1b in Section 14, "UM Criteria Log"). UM staff must be available during normal business hours, Monday through Friday, 8:00 AM to 5:00 PM to answer any UM issues.

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

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

b. On the website, if it notifies practitioners that information is available

5. **Annual Assessment of Consistency of UM Decisions (Inter-rater Reliability):** Practitioners involved in utilization review will be evaluated at least annually for consistency in application of appropriate decision-making criteria.

6. **Behavioral Health Triage and Referral:** The IEHP Behavioral Health Program is responsible for ensuring triage and referral decisions are made according to protocols that define the level of urgency and appropriate setting of care. Triage and referral protocols utilized must be based on sound clinical evidence and currently accepted practices for behavioral health care service delivery.

   a. The protocols address the urgency of the Member's clinical circumstances and define the appropriate care settings and treatment resources that are to be used for behavioral health and substance abuse cases.

   b. Triage and referral staff members must utilize protocols and guidelines that are up-to-date and the staff must be provided appropriate education and training regarding their use.

   c. Protocols used by staff are reviewed and/or revised annually.

   d. IEHP Medicare DualChoice (HMO SNP) Members shall access in-network or respective county agencies for their Behavioral Health needs.

C. **UM Structure:**

1. **UM Medical Director** - There must be a designated physician who holds an unrestricted license in the state of California, responsible for reviewing and monitoring the UM process, including at a minimum, the following activities:

   a. Final decision making on referrals denied or modified for medical necessity or benefit coverage;

b. Review of modified or denied referrals to assure consistent process and decision making;

c. Review of internal physician-specific UM data to assess potential over and under utilization of services;

d. Sign-off on all internal policies and procedures related to UM; and

e. Chairing the UM Committee, or designating a Chair.

2. **UM Committee** - Committee membership must include a minimum of three practicing physicians, representing the appropriate specialties pertinent to IEHP Membership including Obstetrics and Gynecology (OB/GYN), Pediatrics, Family Practice and other specialists, as needed. The UM Committee must meet at least quarterly and perform at a minimum the following activities:

   a. Concurrent review of complex referrals requiring multiple physician input;

   b. Retrospective review of approved and denied referrals to assess consistency of process and decisions;

   c. Review of physician-specific UM data to assess potential under and over utilization; and

   d. Review of appeals or grievances related to UM decisions, as needed, with referral to QM or Peer Review Committee as appropriate.

3. **UM Program Description must include:**

   a. Mission statement, goals, and objectives;

   b. Designated standards used for determination of medical necessity that meet IEHP requirements;

   c. Authorization process, in detail, including staffing and turnaround timeframes;

   d. Evidence of full range of UM activities;

   e. UM Committee meeting frequency;

   f. UM Committee chairperson and membership including a rotation policy;

   g. Documentation of ability to collect and report all required UM data;

   h. Delineation of timeframes for approval or denial of referrals that meet IEHP and regulatory standards;

   i. Denial process that includes letters to Members and practitioners;

   j. Procedures for informing practitioners of referral process; and

k. Dissemination of summary UM data to practitioners

4. **Network Practitioner Responsibilities:** Network practitioners are required to follow established UM procedures for authorization that include:

   a. Providing sufficient information for decision making; or

   b. Following the Health Plan's directions for initiating the UM process.

D. **Use of Appropriate Professionals for UM Decisions:** To ensure that first-line UM decisions are made by individuals who have the knowledge and skills to evaluate working diagnoses and proposed treatment plans, IEHP has adopted standards for personnel making review decisions and reviewing denials. The following types of personnel can perform the functions listed:

1. For medical decisions:

   a. UM Technicians/Coordinators – eligibility determination, editing of referral form for completeness, interface with practitioner office to obtain any needed non-medical information.

   b. RN/LVN – initial review of medical information, initial determination of benefit coverage, obtaining additional medical information, as needed, from the practitioner's office, approval of medically routine referrals, preliminary denial for eligibility.

   c. A physician must supervise review processes and decisions.

   d. A designated California licensed physician (with an unrestricted license) must review all the denials for medical necessity or benefit coverage and obtain additional medical information from treating physician, as needed within the required timeframes. A designated Board Certified physician in the appropriate specialty must be consulted to review all applicable denied referrals and approve complex referrals, as needed.

   e. Compensation arrangements for individuals who provide utilization review services must not contain incentives, direct or indirect, to make inappropriate review decisions. If incentives are used, there is a mechanism in place to ensure that all decisions are based on sound clinical judgment.

   f. Referral decision-making and hospital length of stay information for use with economic profiling must be provided to PCPs, if requested.

2. **Use of Board Certified Physicians for UM Decisions:** IEHP uses designated physicians for UM decisions. When a case review falls outside the clinical scope of the reviewer, or when medical decision criteria do not sufficiently address a case under review, a Board Certified physician in the appropriate specialty may be consulted.

a. Either maintain lists of Specialists to be utilized for UM decisions, or consult with an organization contracted to perform such review. The interaction can be completed by a telephone call to a network specialist, a written request for review, or use of a contracted vendor that provides Board Specialist review.

b. The primary physician reviewer determines the type of specialty required for consultation.

c. IEHP maintains a contract with one or more external review companies, for specialty consultation.

E. **Authorization, Inpatient Review, and Notification Standards:** There must be written policies and procedures regarding the process to review, approve, modify or deny prospective, concurrent, or retrospective requests by providers or practitioners concerning the provision of health care services for Members. These policies and procedures must be available to the public upon request. See Policy 11B, "Prior Authorization for Non-Formulary Medications," for further details regarding pharmaceutical pre-authorization guidelines.

1. **Communication Services**: There must be access to staff for Members and practitioners seeking information about the UM Process and the authorization of care. This includes the following:

a. UM staff are available at least eight hours a day during normal business hours to receive phone calls regarding UM issues;

b. Outbound communication from staff regarding inquiries about UM during normal business hours;

c. Staff identify themselves by name, title, and organization when initiating or returning calls regarding UM issues;

d. There is a toll free number or staff members that can accept collect calls regarding UM issues.

e. Staff can receive inbound communication regarding UM issues after normal business hours;

f. Staff are accessible to callers who have questions about the UM process; and

g. TDD/TTY services for the deaf, hard-of-hearing, or speech impaired, and language assistance are available to all IEHP Members. Both are the Health Plan's responsibility. IEHP will audit to assure that all policies and procedures state that Delegates direct all Members to IEHP when these services are needed.

2. **Authorization and Notification for Referrals or Services:** Authorization and notification of decision for proposed services, referrals, or hospitalizations at the practitioner level involves utilizing information such as medical records, test reports, specialists consults, and verbal communication with the requesting practitioner in the review determination. Part of this review process is to determine if the service requested is available in network. If the service is not available in network, arrangements are made for the Member to obtain the service from a non-network provider for this episode of care. A process must be in place for the coordination of medically necessary care from the non-network specialist.

   a. **Prior Authorization of Non-urgent Pre-Service Organization Determinations:**

      1) The prior authorization process is initiated when the Member's physician requests a referral or authorization for a procedure or service with the exception of vision services, or hospitalization.

      2) The timeframes for completion and adjudication of the referral are as follows:

         a) **Practitioners** have two working days from the determination that a referral is necessary to submit the referral and all supporting documentation. Practitioners must sign and date the referral and provide a direct phone number and fax number to the referring physician for any questions or communication regarding the referral.

            The decision to approve, modify, or deny, must be made according to industry standards (see Attachment 14-12 in Section 14, "Attachments").

         b) The timeframe begins from receipt of the request. If information necessary to make a determination is not available with the referral, the requesting practitioner should be contacted preferably by telephone for the additional clinical information. The request for additional information must be annotated and must include the date of the request.

         c) Practitioners must be initially notified within 24 hours of the decision by telephone. If the practitioner cannot be reached by telephone, a fax can be utilized. Telephonic communications of decisions must be documented including date, time, name of contact person, and initials of person making the call.

         d) Both the Member and practitioner must be notified in writing, of all decisions.

b. **Prior Authorization for Expedited Initial Organization Determinations (EIOD):**

1) Urgent/EIOD pre-service decisions are required if:

   a) Delay could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, based on a prudent layperson's judgment; or

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

2) Prior authorization is not required for services necessary to treat and stabilize an emergency medical condition.

3) The Member, Member designee or the practitioner on behalf of the Member may initiate an EIOD.

4) Practitioners must submit urgent referrals the same day of the determination that the referral is necessary. Decisions to approve, modify, or deny regarding prior authorization must be made according to industry standards (see Attachment 14-12 in Section 14, "Attachments").

5) The timeframe begins from the time and date the request is received. If information reasonably necessary to make a determination is not available with the referral, the requesting practitioner should be contacted for the additional clinical information preferably by telephone. The request for additional information must be annotated and must include the date of the request.

6) Practitioners must be initially notified within 24 hours of the decision by telephone or fax. Telephonic communications of decisions must be documented including date, time, name of contact person, and initials of person making the call.

7) Both the Member and practitioner must be notified in writing, of all decisions.

d. **Post-Service Organization Determinations (Retrospective Review):**

1) Retrospective review decisions and written notification to the Member and practitioners must be made within 14 days from receipt of the request.

2) Members do not need written notification of the decision in the following situations:

a) Retrospective review is only to determine payment level; or

b) The Member is not at financial risk.

[For example, a retrospective billing adjustment of an Emergency Department visit does not require Member notification because the services have already been rendered, the Member is not financially impacted by the decision (being dual eligible), and payment must be made for the medical screening exam (MSE)]

e. **Experimental and Investigational Determinations:**

1) The determination for all experimental and investigational services is the responsibility of IEHP. IEHP is responsible for decision-making and notifying the provider and Member of the determination, per standard timeframes for level of urgency, utilizing the appropriate CMS notification letter template.

f. **Denial Notices**: Any denial, in whole or in part, of a requested health care service must be reviewed and approved by the UM Medical Director, physician designee, or UM Committee.

g. **Denial letters must include the following** (see Attachments 14-7a through 14-11b and 14-13a through 14-15b in Section 14, "Attachments"):

1) Required CMS denial language (utilizing only approved CMS denial letter templates);

2) Be typed in 12-point font;

3) Language appropriate for the Member population describing the reason for the denial;

a) Medical necessity denials must cite the criteria used and the reason why the clinical information did not meet criteria;

b) Non-covered benefit denials must cite the specific provision in the Evidence of Coverage (EOC) that excludes that coverage or the IEHP Member Handbook, CMS guideline or State/Federal regulations including the page number and/or State Regulations section.

c) Information on how the Member and practitioner can obtain the utilization criteria or benefits provision used in the decision;

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

5) Information on how to file an oral or written expedited grievance, file a standard or fast appeal, or file an immediate review or appeal with the Quality Improvement Organization (QIO) as applicable.

h. The written communication to a practitioner of a denial based on medical necessity, must include the name and telephone number of the UM Medical Director or physician designee responsible for the denial to offer the requesting practitioner the opportunity to discuss any issues or concerns regarding the decision within 72 hours of the initial notification of the denial or modification. This written notification of denial or modifications must include language informing the practitioner of their right to appeal the decision to the Medical Director.

i. IEHP shall retain information on decisions, i.e., authorizations, denials, appeals, grievances, or modifications for a minimum period of ten years.

j. **Exceptions:** Prior authorization is not required for the following services:

1) Family Planning and Abortion Services;

2) Sexually transmitted disease (STD) treatment;

3) Sensitive and Confidential Services;

4) HIV testing and counseling at the Local Health Department;

5) Immunizations at the Local Health Department; and

6) Routine OB/GYN services, including prenatal care by Family Care Practitioner (credentialed for obstetrics) within the IEHP network.

3. **Emergency Services:** Prior authorization is not required for the medical services necessary to treat and stabilize a life-threatening emergency. IEHP has adopted the following definition for an emergency medical condition:

a. Emergency Medical Condition means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

2) serious impairment to bodily function; or

3) serious dysfunction of any bodily organ or part.

b. For further details see Policy 14D, "Emergency Services." All emergency care costs are covered when authorized by IEHP or its designee.

4. **Standing Referrals:** There must be procedures by which a PCP may request a standing referral to a specialist for a Member who requires continuing specialty care over a prolonged period of time or an extended referral to a specialist for a Member who has a life threatening, degenerative, or disabling condition that requires coordination of care by a specialist. Authorization should be for a 3-6 month period.

5. **Behavioral Health:** Behavioral Health benefits for IEHP Medicare DualChoice (HMO SNP) Members are obtained through the IEHP Behavioral Health Program.

6. **Vision Services:** Are not a Medicare benefit unless specifically for covered lenses post cataract surgery. Dual Eligible Members may have additional benefits.

7. **Pharmacy Services:** IEHP does not delegate the responsibility for UM associated with pharmacy services. Please refer to the Pharmacy Services manual for further details.

F. **UM Requirements** – The following requirements for UM processes must be met:

1. **Services Requiring Prior Authorization:** A list of services that require prior authorization or a list of services that do not require prior authorization must be maintained.

2. **Medical Necessity Determination:** Medical necessity determinations for a specific requested service is as follows:

   a. Utilize a definition for medical necessity which includes all health care services necessary for the diagnosis and/or treatment of a medical condition causing significant pain, negative impact on the health status of the Member, potential disability or is potentially life threatening;

   b. Employ IEHP approved UM standards including but not limited to: Center for Medicare and Medicaid Services (CMS), IEHP UM Subcommittee Approved Authorization Guidelines, Milliman Care Guidelines, InterQual, and Apollo Managed Care Guidelines/Medical Review Criteria.

   c. Take into account all factors related to the Member including barriers to care related to access or compliance, impact of a denial on short and long term medical status of the Member and alternatives available to the Member if denied; and

   d. Obtain input from specialists in the area of the health care services requested either through a UM Committee member, telephonically, or with an outside consultant.

3. **Denials because the requested service or procedure is not a covered benefit:** The IEHP Benefit Manual and other supporting regulations must be utilized to determine if a requested service or procedure is a covered benefit. Denial letters must cite the specific non-covered benefit.

4. **Denials due to the Member not being eligible:** Current eligibility or eligibility for the time period that services were rendered, should be verified to determine if the Member is eligible.

5. **Referral Requests:** The PCP provides general medical care for Members. Referral to specialists, or authorization for procedures, services, or hospital admissions, should be initiated by PCPs through the UM Medical Director and/or UM Committee. Specialists caring for Members can request referrals directly.

G. **Documentation of Medical Information and Review Decisions:** Review decisions must be based on documented evidence of medical necessity provided by the attending physician. Regardless of criteria, the Member's condition must always be considered in the review decision.

1. **Physician Documentation:** Attending physicians must maintain adequate medical record information to assist the decision-making process. The PCP must document the medical necessity for requested services, procedures, or referrals and submit all supporting documentation with the request.

2. **Reviewer Documentation:** Reviewers must abstract and maintain review process information in written format for monitoring purposes. Documentation must be legible, logical, and follow a case from beginning to end. Rationale for approval, modification or denial must be a documented part of the review process. Decisions must be based on clinical information and sound medical judgment with consideration of local standards of care.

3. **Documentation:** Procedures must be in place to log requests by date and receipt of information so that timeframes and compliance with those timeframes can be tracked. Documentation of authorizations or referrals must include, at a minimum: Member name and identifiers, description of service or referral required, medical necessity to justify service or referral, place for service to be performed or name of referred physician, and proposed date of service. Documentation must also include a written assessment of medical necessity, appropriateness of level of care, and decision. Any denial of a proposed service or referral must be signed by the UM Committee, Medical Director, or physician designee. Written notifications to a practitioner of a denial must include the name and telephone number of the UM Medical Director or physician designee responsible for the denial.

4. **Affirmative Statement Regarding Incentives:** UM decisions for Members must be based only on appropriateness of care and service. IEHP does not provide

compensation for practitioners or other individuals conducting utilization review for denials of coverage or service. IEHP ensures that IEHP or contracts with physicians do not encourage or contain financial incentives for denial of coverage or service. The Affirmative Statement about incentives is distributed annually to all practitioners, providers, employees and Members.

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

6. **Discharge Planning:** The UM process must include the following activities related to discharge planning:

   a. Determining level of care (SNF, office visit, home health, home without services);

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

   c. Facilitating transfer of the discharge summary and/or medical records, as necessary, to the PCP office.

7. **Out of Network Management:** Out of Network Management includes arranging for the transfer of Members, as medically appropriate, back into the IEHP network.

8. **Review of UM Data:** UM data related to Members is collected, reported, and analyzed for potential over or under utilization.

   a. UM data includes, at a minimum, the following:

      1) Enrollment
      2) Re-admits within 31 days of discharge;
      3) Total number of prior authorization requests;
      4) Total number of denials;
      5) Denial percentage; or
      6) Emergency encounters.

   b. Presentation of above data in summary form to the UM Subcommittee for review and analysis at least quarterly upon receipt of necessary information;

   c. Presentation of selected data from above to PCPs, specialists, and/or Hospitals as a group, e.g., Joint Operating Meetings (JOMs), or individually, as appropriate; and

   d. Evidence of review of data above by the UM Subcommittee for trends by physicians for both over-utilization and under-utilization.

H. **Appeals and Grievance Non-Urgent Process:** IEHP maintains a formal Appeals and Grievance Resolution System to ensure a timely and responsive process for addressing and resolving all Member appeals and grievances. IEHP acknowledges and resolves UM related appeals and grievances in accordance with state and federal regulatory guidelines. The Member may file an appeal or grievance by phone, by mail, fax, website, or in person. IEHP resolves Member appeals and grievances within industry standard time frames. Please refer to Section 16 of this manual, "Grievance Resolution System."

I. **Second Opinions:** Members, PCPs and specialists have the right to request a second opinion regarding proposed medical or surgical treatments from any IEHP participating practitioner. Second opinions are authorized and arranged through the authorization system. In cases in which the Member faces imminent and serious threat to his/her health, including but not limited to the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the Member's ability to regain maximum function, decisions and notification of decisions to practitioner are completed in a timely fashion not to exceed 72 hours after receipt of request. If the referral for a second opinion is approved, arrangements must be made for the Member to see a physician in the appropriate specialty. If the referral is denied, written notification must be sent to the Member including rationale for the denial. Members disagreeing with a denial of a second opinion may register an appeal through IEHP's appeal and grievance process. Refer to Policy 14C, "Second Opinions" for more information.

J. **New Technology:** The IEHP UM Subcommittee is responsible for reviewing new medical technologies and new applications of existing technologies for potential addition as a medical benefit for Members. The IEHP Chief Medical Officer or Medical Director will identify and research new technology and new applications of existing technologies, including medical procedures, treatment, and devices. Research and investigation includes review of scientific information, such as ECRI's Health Technology Information Services, and review of regulatory body publications from such agencies. Information is then presented to the UM Subcommittee regarding the technology/product, its scope and limitations. The UM Subcommittee obtains an opinion from an appropriate specialist physician whenever necessary to assist in the decision regarding coverage of a new technology as a covered benefit for Members. Once approved by the UM Subcommittee, the IEHP Chief Medical Officer/IEHP Medical Director presents the new benefit/service, including scope and limitations, to the IEHP QM Committee for approval.

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

L. **UM Responsibilities:** IEHP retains responsibility for selective UM activities for non-covered benefits, authorizations for vision services, pharmacy services and behavioral health authorizations. An electronic authorization system is maintained by IEHP to accommodate authorizations by IEHP for services that are not covered under the

Medicare contract but are authorized by the IEHP Chief Medical Officer or Medical Director. Examples include special lenses, abortions under special circumstances, or special referrals/treatment out-of-network.

M. **Monitoring Activities and Oversight:** IEHP monitors UM activities. The following oversight activities are performed to ensure compliance with IEHP UM and regulatory standards:

1. **Delegate and Hospital Contracts** – The IEHP Agreements contain language that designates compliance requirements for participation in an ongoing utilization management program to promote efficient use of resources.

2. **Analysis of Provider Data Reports** - Review of required IEHP reports and utilization data including denial logs and letters, UM trend reports, Behavioral Health UM reports, EIOD log, second opinion log, annual & semi-annual work plan, is done by the IPA UM Liaison and Director of Utilization Management.

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

4. **Medical Management Audits (MMA)**: IEHP performs monthly denial letter audits and the annual onsite Medical Management audits of all Delegates to review the UM process, that includes approved referral audit and non-emergent file review.

5. **Joint Operating Meetings (JOMs):** JOMs are intended to provide a forum to discuss issues and ideas concerning care for Members. JOMs may address specific UM, QM, CM, grievance, study results, or any other pertinent quality issues affecting practitioners and Hospitals. They are held with Hospitals and providers. These meetings are designed to address issues from an operational level.

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

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Effective date:**	January 1, 2007
Chief Title: Chief Medical Officer	**Revised date:**	January 1, 2012

B. Review Procedures

1. Primary Care Physician (PCP) Referrals

APPLIES TO:

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

POLICY:

A. IEHP delegates the responsibility for providing general medical care for Members to PCPs.

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

PROCEDURE:

A. Referrals to specialists, second opinions, hospital admissions, or any service which requires prior authorization are initiated by PCPs or specialists through the prior authorization process. Prior authorization of proposed services, referrals, or hospitalizations involve the following:

   1. Verification of Member eligibility;

   2. Written documentation by the PCP or specialist of medical necessity for service, procedure, or referral;

   3. Verification that the place of service, referred to practitioner, or specialist is within the IEHP network; and

   4. Assessment of medical necessity and appropriateness of level of care with determination of approval or denial for the proposed service or referral.

B. PCPs must maintain a Referral Tracking Log for all referrals submitted for approval, in accordance with Policy 14B1a, "PCP Referral Tracking Log." The prior authorization/referral process must meet all standards, including timeliness, as delineated in Policy 14A, "Utilization Management Delegation and Monitoring."

C. The PCP informs Members that if the referral is denied or modified, they can file an appeal or grievance with IEHP. A written notice of denial must be provided that includes the appeal and grievance process.

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

E. Members requiring special tests/procedures or referral to a specialist may have to obtain prior authorization.

1. Each specialist provides written documentation of findings and care provided or recommended to the PCP within two weeks of the Member encounter.

2. The PCP evaluates the report information, initials and dates the report once reviewed, and formulates a follow-up care plan for the Member. This follow-up plan must be documented in the Member's medical record.

3. The presence of specialist reports on the PCP's medical records is assessed during periodic chart audits by IEHP.

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

G. Referrals for behavioral health services for Members are initiated by the PCP through IEHP as outlined in Policies 12D1, "Behavioral Health Services" and 12D2, "Alcohol and Drug Treatment Services."

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Effective date:**	January 1, 2007
Chief Title: Chief Medical Officer	**Revised date:**	January 1, 2009

14. UTILIZATION REVIEW

B. Review Procedures

1. Primary Care Physician (PCP) Referrals

a. PCP Referral Tracking Log

APPLIES TO:

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

POLICY:

A. All PCPs must maintain a system for tracking all referrals submitted to IEHP.

PROCEDURE:

A. All PCPs must maintain a referral log that contains all of the information noted below:

1. Date referral sent for review;
2. Member Name;
3. Member IEHP ID number;
4. Acuity of referral (Emergent, Urgent, or Routine);
5. Reason for Referral or Diagnosis;
6. Service/Activity Requested;
7. Date referral returned;
8. Referral Decision (Approved, Modified, Denied);
9. Date Patient Notified;
10. Date of Appointment or Service; and
11. Date Consultation or other Report Received.

B. PCPs may either use the PCP Referral Tracking Log (see Attachment 14-2 in Section 14, “Attachments”) or another system that contains all of the above-required information.

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

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

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

14. UTILIZATION MANAGEMENT

B. Review Procedures

2. Standing Referral/ Extended Access to Specialty Care

APPLIES TO:

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

POLICY:

A. PCPs can request a standing referral to a specialist for a Member who, as a component of ongoing ambulatory care, requires continuing specialty care over a prolonged period of time, or extended access to a specialist for a Member who has a life threatening, degenerative or disabling condition that requires coordination of care by a specialist.

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

C. Practitioners that are Board Certified in appropriate specialties, e.g., Infectious Disease, are able to treat conditions or diseases that involve a complicated treatment regimen that requires ongoing monitoring. Board certification is verified during the provider credentialing process. Members may obtain a list of practitioners who have demonstrated expertise in treating a condition or disease involving a complicated treatment regimen that requires ongoing monitoring by contacting IEHP at (877) 273-4347.

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

PROCEDURE:

A. Processes must be implemented for standing referrals or extended access to a specialist if the PCP determines, in consultation with the specialist as needed, and the Medical Director or designee, that a Member needs continuing care from a specialist.

B. After consultation with the specialist as needed, and the Medical Director, the PCP must submit his/her request for a standing referral or extended access to specialty care referral in writing, using the designated form (see Attachment 14-3 in Section 14, "Attachments"). Appropriate medical records must be attached to the request.

C. Standing referrals are processed according to turn around timeframes as outlined in Policy 14A, "Utilization Management Delegation and Monitoring."

D. After approval of the standing referral or extended access to specialty care with or without a treatment plan, the PCP, specialist and Member must be notified in writing of the specifics of the determination, within two business days of the determination.

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

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

1. Significant cardiovascular disease;
2. Asthma requiring specialty management;
3. Diabetes requiring Endocrinologist management;
4. Chronic obstructive pulmonary disease;
5. Chronic wound care;
6. Rehab for major trauma;
7. Neurological conditions such as multiple sclerosis, uncontrollable seizures among others; and
8. GI conditions such as severe peptic ulcer, chronic pancreatitis among others.

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

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

H. When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, the Member must be referred to an HIV/AIDS specialist. When authorizing a standing referral to a specialist for the purposes of having that specialist coordinate the Member’s care who is infected with HIV, the Member must be referred to an HIV/AIDS specialist. An HIV/AIDS specialist is a physician who holds a valid, un-revoked and unsuspended certificate to practice medicine in the state of California who meet any one of the following four criteria:

1. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine (AAHIVM); or

2. Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a certificate of Added Qualification, in the field of HIV medicine; or

3. Is board certified in the field of infectious diseases and meets the following qualifications:

   a. In the preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and

   b. In the preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education, (as directed by the Medical Board of California), in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or

4. Meets the following qualifications:

   a. In the preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and

   b. Has completed any of the following;

      1) In the preceding 12 months has obtained board certification or recertification in the field of infectious diseases; or

      2) In the preceding 12 months has successfully completed a minimum 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or

      3) In the preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the AAHIVM.

5. The HIV/AIDS specialist may utilize the services of a nurse practitioner or physician assistant if:

a. The nurse practitioner or physician assistant is under the supervision of an HIV/AIDS specialist; and

b. The nurse practitioner or physician assistant meets the qualifications specified in this policy; and

c. The nurse practitioner or physician assistant and the supervising HIV/AIDS specialist have the capacity to see an additional patient.

6. The Member may be referred to a non-network provider if there is no HIV/AIDS specialist, or appropriately qualified nurse practitioner or physician assistant under the supervision of an HIV/AIDS specialist within the network appropriate to provide care to the Member, as determined by the Medical Director and/or PCP in consultation with IEHP's Chief Medical Officer, when warranted.

I. Any medical condition requiring frequent or repeat visits to a specialist should be considered by the PCP for submission of a standing referral or extended access to a specialty care referral.

Out of Network

A. Members can be referred to out-of-network practitioners when appropriate specialty care is not available within the network.

B. All services for out-of-network provides must be coordinated adequately and timely.

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

D. Members can be referred to an out-of-network HIV/AIDS specialist when an appropriate HIV/AIDS specialist, or qualified nurse practitioner or physician assistant under the supervision of an HIV/AIDS specialist is not available within the network, as determined by the Medical Director and/or PCP in conjunction with the Chief Medical Officer, as warranted.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Effective date:**	January 1, 2007
Chief Title: Chief Medical Officer	**Revised date:**	January 1, 2012

14. UTILIZATION MANAGEMENT

C. Second Opinions

APPLIES TO:

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

POLICY:

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

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

PROCEDURES:

A. The Member's request for a second opinion is processed through the prior authorization system. Members should request a second opinion through their PCP or specialist. If the PCP or specialist refuses to submit a request for a second opinion, the Member can submit a grievance or a request for assistance through IEHP Member Services at (877) 273-4347. IEHP's Member Services staff directs the Member to an IEHP Care Manager. The Care Manager assists the Member in requesting a second opinion.

B. The PCP or specialist should submit the request for a second opinion with documentation regarding the Member's condition and proposed treatment.

C. If the referral for a second opinion is approved, arrangements should be made for the Member to see a physician in the appropriate specialty. Agreements with any network or non-network practitioner for second opinions must include the requirement that the consultation report for the second opinion be submitted within three working days of the visit to the Practitioner. If the referral is denied or modified, written notification to the Member must include the rationale for the denial or modification, alternative care recommendations, and information on how to appeal this decision.

D. If there is no physician within the IEHP network that meets the qualifications for a second opinion, the authorization must be given for a second opinion by a qualified physician outside IEHP's network and ensure that cost to the Member is not greater than it would be if the services were furnished within the network.

E. All services for out-of-network provides must be coordinated adequately and timely.

F. Members disagreeing with a denial of a second opinion may appeal through the IEHP grievance process. Refer to Section 16, "Grievance Resolution System" for more information.

G. In cases where the Member faces an imminent and serious threat to his or her health, including but not limited to, the potential loss of life, limb or other major bodily function, or lack of timeliness that would be detrimental to the Member's ability to regain maximum function, decisions and notification of decisions to practitioners are completed in a timely fashion not to exceed 72 hours after receipt of request, whenever possible.

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

I. A Second Opinion Tracking Log (see Attachment 14-4 in Section 14, "Attachments") should be maintained to track the status of second opinion requests and to ensure that the second opinion practitioner submits the consultation report within three working days of the visit. The Log must include all authorized, modified, and denied second opinions.

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

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

K. If the Member is requesting a second opinion about care from his or her PCP, the second opinion must be provided by an appropriately qualified physician of the Member's choice.

L. If the Member is requesting a second opinion about care from a specialist, the second opinion must be provided by any physician of the same or equivalent specialty of the Member's choice within the IEHP network. If not authorized, additional medical

opinions obtained by a physician not within the IEHP network are the responsibility of the Member.

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

N. The second opinion practitioner is responsible for submitting consultation reports to the Member, requesting practitioner and PCP within three working days of the visit. If the second opinion is deemed urgent, the submission of the consultation report must be within 24 hours of the visit.

O. The PCP is responsible for documenting second opinions and monitoring receipt of consultation reports on the Referral Tracking Log (see Attachment 14-2 in Section 14, "Attachments").

P. Mandated timeframes for decision including approval, denial or modification of a request for a second opinion and subsequent notification to the Member and practitioner is outlined in Policy 14A, "Utilization Management Delegation and Monitoring."

D. Emergency Services

APPLIES TO:

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

POLICY:

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

B. Per regulatory requirements, IEHP has adopted the "prudent layperson" definition of an emergency medical condition, as follows:

   1. Emergency Medical Condition means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

      b. Serious impairment to bodily function; or

      c. Serious dysfunction of any bodily organ or part.

C. IEHP is financially responsible for services associated with the diagnosis and/or treatment of a Member's visit to an ED when the ED visit was authorized by the PCP or IEHP designee regardless of whether the visit was emergent or non-emergent.

D. If it is determined that the Member's condition was not emergent, IEHP is responsible for the MSE, at a minimum. The Member does not need to be notified of an ED denial. The Member is not financially responsible and must not be billed for any difference between the amount billed by the Hospital and amount paid.

E. Emergency services can be subject to retrospective review. IEHP may retrospectively review claims and adjust payment if services provided were beyond the scope of the authorization and were not medically necessary. A retrospective billing adjustment of an Emergency Department visit does not require Member notification because the Member is not financially impacted by the decision, and payment must be made for the MSE.

PROCEDURES:

A. Final determination of whether or not an emergency medical condition existed can be subject to medical review by a physician; however, the prudent layperson definition must be utilized in the review.

   1. Medical decision criteria and diagnosis codes may be utilized in the review process; however, under the prudent layperson definition, the review must also

take into account emergency medical conditions that present acutely but result in benign diagnoses. Examples include:

a. 2-year old with 103° fever, listless, less responsive, vomiting - Otitis Media;

b. 38-year old with acute, severe chest pain - Costochondritis;

c. 17-year old female with severe lower abdominal pain, vaginal bleeding - Spontaneous Abortion - complete;

d. 12-year old with severe shortness of breath, cough - Asthma;

e. 60-year old with fever to 104°, severe cough, acute shortness of breath - Bronchitis;

f. 23-year old pregnant woman with lower abdominal pain, fever, perceived decreased fetal movement - Urinary Tract Infection;

g. 12-year old with severe abdominal pain, vomiting fever - Adenitis, Mesenteric; or

h. Sudden onset of behavioral changes or an exacerbation of a known psychiatric diagnosis - Adjustment Disorder.

2. A physician must perform review of retrospective billing adjustments or reduction of payments of claims.

B. Prior authorization is not required for the MSE (or COBRA exam) performed at an ED, to the extent necessary to determine the presence or absence of an emergency medical condition, or for services necessary to treat and stabilize an emergency medical condition. If the MSE demonstrates that an emergency medical condition is not present, ED personnel must contact the PCP or designee for authorization of services or treatment beyond the MSE.

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

D. In the event that the ED is unable to reach the responsible PCP or designee, the call time and phone number must be documented in the ED record and the ED must provide medically necessary care.

E. Examples of non-emergent ED visits could include:

1. Possible fractures (sprain – rule out fracture);

2. Simple lacerations;

3. Mild asthma exacerbation;

4. Small animal bites; or

5. High fever without systemic symptoms.

14. UTILIZATION MANAGEMENT

E. Pre-Service Referral Authorization Process

APPLIES TO:

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

POLICY:

A. To ensure timely access to specialty care for IEHP Medicare DualChoice (HMO SNP) Members, IEHP has established and implemented mandated guidelines.

B. PCPs are responsible for providing general medical care for Members and requesting specialty care, diagnostic tests, and other medically necessary services through IEHP's referral authorization process.

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

D. IEHP must have a process in place to allow a specialist to directly request authorization from IEHP for additional specialty consultation, diagnostic or therapeutic services.

E. IEHP should evaluate PCP and specialist referral patterns for over and under utilization.

PROCEDURES:

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

B. Referral forms from the PCP or specialist must include the following information:

   1. Designation of the referral request as either routine or urgent to define the priority of the response. Referrals that are not prioritized are handled as "routine." Referrals that are designated as urgent must include the supporting documentation regarding the reason the standard time frame for issuing a determination could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function;

   2. The diagnosis (ICD-9) and procedure (CPT) codes;

   3. Pertinent clinical information supporting the request; and

   4. Signature of referring physician and date.

C. Upon receipt of the referral, IEHP is responsible for verification of Member eligibility and plan benefits.

D. IEHP must have a process that facilitates the Member's access to needed specialty care by prior authorizing at a minimum a consult and follow up visit (a total of two visits) for

medically necessary specialty care (see Attachment 14-5 in Section 14, "Attachments").

E. Prior authorization for medically necessary procedures or other services that can be performed in the office, beyond the initial consultation and follow up visit, should be authorized as a set or unit. For example, when approving an ENT consultation for hearing loss, an audiogram should be approved (see Attachment 14-5 in Section 14, "Attachments").

F. Decisions for referrals must be made in a timely fashion not to exceed regulatory turnaround time frames for determination and notification of Members and practitioners.

G. IEHP should monitor the PCP's rates of referrals to specialists to:

1. Monitor for potential over or under utilization of specialists; and
2. Identify referral requests that are within the scope of practice of the PCP.

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

I. There must be documented evidence of the corrective action taken by IEHP, including the PCP's response to the intervention. The PCP's referral pattern must be re-evaluated after a sufficient amount of time (at least sixty days) has elapsed to monitor effectiveness.

J. Specialists are required to forward consultation notes to the PCP within two weeks of the visit.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Effective date:**	August 1, 2007
Chief Title: Chief Medical Officer	**Revised date:**	January 1, 2009

14. UTILIZATION MANAGEMENT

F. Wheelchair Purchase Referral Procedure

APPLIES TO:

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

POLICY:

A. For wheelchair purchase requests, IEHP may require a medical necessity evaluation.

1. Wheelchair medical necessity evaluations will be performed by a physiatrist, orthopedist, neurologist, rheumatologist, or other qualified medical professional as authorized by IEHP.

B. IEHP will coordinate a Seating Evaluation, either facility based or in-home, for Members who need custom wheelchairs, power wheelchairs, non-routine wheelchair therapeutic seat cushions, and/or wheelchair positioning systems.

PROCEDURES:

A. Prior to the submission of a request to IEHP for the purchase of a wheelchair, the Member must have an evaluation for medical necessity by a physiatrist, orthopedist, neurologist, or rheumatologist.

B. If the request for the purchase of a custom wheelchair meets criteria based on the specialist evaluation, IEHP will send notification to the requesting provider, PCP, and the Member.

C. IEHP's UM Department will send notification to care management for assistance with coordination of services.

D. IEHP will arrange for the Member to be assessed for a Seating Evaluation, either facility-based or in the home, to determine equipment needs.

E. Unless otherwise informed that the equipment will be delivered to the Member's home, all equipment assessed for the Member will be delivered to the Seating Evaluator as applicable.

F. The Seating Evaluator will contact the Member and schedule a post delivery assessment that will include the DME vendor, as needed.

INLAND EMPIRE HEALTH PLAN		
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Chief Title: Chief Medical Officer	**Revised date:**	January 1, 2011

G. Inpatient Review/Notice of Non-Coverage of Continued Inpatient Hospital, Skilled Nursing Facility, Home Health Agency, or Comprehensive Outpatient Rehabilitation Facility Services

APPLIES TO:

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

POLICY:

A. Inpatient review is the process to determine the medical necessity of inpatient services. Concurrent Review is a process designed to monitor appropriateness and quality of healthcare in the institutional setting at the time the services are rendered.

B. The hospital is responsible for notifying the Member of their right to a Quality Improvement Organization (QIO) review of discharge decisions by delivering the "Important Message From Medicare About Your Rights" (IM) notice.

C. The IM should be given to Members at the inpatient level, whether the care is short or long term, acute or non-acute, rehabilitation hospitals, long term care hospitals and psychiatric hospitals.

D. Members in hospital swing beds or custodial care beds do not receive these notices when receiving services at a lower level of care.

E. The Member must be notified of decisions to terminate Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services no less than two days before the proposed end of the services.

F. Members do not need a three day acute hospital stay prior to admission to a SNF.

PROCEDURE:

A. Hospitals must notify Members who are inpatient about their hospital discharge appeal rights. Hospitals must issue the IM (see Attachment 14-16 in Section 14, "Attachments") within 2 calendar days of admission, must obtain the signature of the beneficiary or his or her representative and provide a copy at that time.

   1. A follow up copy must be delivered as far in advance of discharge as possible, but no less than 2 calendar days before the planned date of discharge.

   2. When discharge cannot be predicted in advance, the follow-up copy may be delivered as late as the day of discharge giving the beneficiary at least 4 hours to consider their right to request a QIO review.

   3. If delivery of the original IM is within 2 calendar days of the date of discharge, no

follow up notice is required.

(Example: The Member is admitted on a Monday, the IM is delivered on Wednesday, and the Member is discharged on Friday, no follow up notice is required.)

B. The IEHP UM Nurse is notified of a Member admission through census sheets or a call/fax from the facility.

C. The IEHP UM Nurse conducts the initial review within 24 hours of notification or the first working day after the admission.

D. Discharge planning is initiated at the time of the initial review.

E. No authorization number for an admission will be issued until all the clinical reviews, the discharge date and discharge needs have been received.

F. The IEHP UM Nurse will review the clinical information utilizing appropriate clinical guidelines.

G. When the admit or continued stay does not meet guidelines, the IEHP UM Nurse will contact the attending or treating physician to discuss the medical necessity and treatment plan for inpatient services.

H. If medical necessity is not met and the treating physician disagrees with discharging the Member, the IEHP UM Nurse will notify the IEHP Medical Director. The IEHP Medical Director or designee will contact the treating physician by telephone to discuss the Member's treatment plan.

I. Once the treating physician concurs with the discharge or transition to a lower level of care, the Practitioner or hospital staff will inform the Member of the planned discharge date (see Attachments 14-15a and 14-15b in Section 14, "Attachments").

J. A Member has a right to request an expedited review by the QIO, when it has been determined, and the physician concurs, that inpatient care is no longer necessary.

   1. In order to be considered timely, the request must be made no later than midnight of the day of discharge, may be in writing or by telephone, and must be before the Member leaves the hospital.

      a. The Member may submit written evidence to be considered by the QIO.

      b. Unfavorable determination: QIO notifies Member that the QIO did not agree with the Member, liability for continued services begins at noon of

the day after the QIO notifies the Member that the QIO agreed with the hospital's discharge determination, or as otherwise determined by the QIO.

c. Favorable Determination: QIO notifies Member that the QIO agreed with the Member, the Member is not financially responsible for continued care, until it is once again determined that the Member no longer requires inpatient care, and the physician responsible for the Member's care concurs with this decision.

2. Members who fail to make a timely request for an expedited review and are no longer an inpatient, can still request a QIO review within 30 calendar days of the date of discharge, or at any time for good cause.

3. As soon as possible, but no later than noon of the day after the QIO notifies a hospital and/or IEHP of the request for expedited review, the hospital must deliver the Detailed Notice of Discharge (see Attachments 14-15a and 14-15b in Section 14, "Attachments") to the Member.

4. The Detailed Notice of Discharge must contain (see Attachments 14-15a and 14-15b in Section 14, "Attachments"):

   a. Detailed explanation why services are either no longer reasonable and necessary or are otherwise no longer covered;

   b. Description of any applicable Medicare coverage rule, instruction, Medicare policy, including information about how the Member may obtain a copy of the Medicare policy;

   c. Facts specific to the beneficiary and relevant to the coverage determination that are sufficient to advise the Member of the applicability of the coverage rule or policy to their case; and

   d. Any other information required by the Centers of Medicare and Medicaid Services (CMS).

5. If the Member requests, the hospital or IEHP must furnish the Member with a copy of, or access to, any documentation that is sent to the QIO, including written records or any information provided by telephone.

   a. The hospital or IEHP must accommodate the request by no later than the first day after the material is requested.

K. The IEHP UM Nurse will coordinate the continued care and discharge plans with the facility's Case Manager.

L. Practitioners and Members are given written or electronic notification of the decision of non-coverage of further SNF, HHA, or CORF care no later than two calendar days or two visits prior to the proposed termination of services. The Notice of Medicare Non-Coverage (NOMNC) letter may be delivered earlier if the date that coverage will end is known. If the expected length of stay or service is two days or less, the NOMNC letter must be given on admission. The NOMNC letter must include (see Attachments 14–14a and 14-14b in Section 14, "Attachments"):

1. Member name;
2. Delivery date;
3. Date that coverage of services will end;
4. QIO contact information for a fast track appeal;
5. Member's right to submit evidence to the QIO; and
6. Alternative appeal mechanisms if the Member fails to meet the deadline for a fast track appeal.

M. The NOMNC should not be used when it is determined that the Member's services should end based on the exhaustion of benefits, (such as the 100-day SNF limit). The Notice of Denial of Medical Coverage (NDMC) letter should be issued (see Attachments 14-13a and 14-13b in Section 14, "Attachments") for this circumstance.

N. If the provider is unable to personally deliver the NOMNC to a person legally acting on behalf of a Member, then the provider should telephone the representative to advise him or her of the following:

1. The proposed termination of services; and
2. The Member's appeal rights must be explained and the name and telephone number of the QIO should be provided.

O. The date of the conversation with the Member's representative is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date.

P. When direct phone contact cannot be made, the notice is sent to the Member's representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt for the NOMNC letter.

Q. Upon notification by the QIO that a Member has filed a request for a fast track appeal, the Detailed Explanation of Non-Coverage (DENC) (see Attachments 14-8a and 8b in Section

14, "Attachments") notice must be sent to the Member by the close of business on the day the QIO notification is received.

1. The notice must include an explanation as to why the services are no longer reasonable or necessary, or are no longer covered.
2. The notice must include the applicable Medicare rule, instruction, or policy, including citations and how the Member can obtain a copy.
3. The notice must include other facts or information relevant to the non-coverage decision.

H. Expedited Initial Organization Determinations (EIOD)

APPLIES TO:

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

POLICY:

A. IEHP processes expedited initial organization determinations (EIOD) for time sensitive situations for Members when the standard timeframe for issuing a determination could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.

B. The Member, applicable representatives, or treating practitioner may submit an oral or written request for an EIOD.

PROCEDURES:

A. The Member, applicable representatives or treating practitioner, may submit requests for EIODs verbally, by fax, or in writing.

B. A Member, applicable representatives, or a practitioner may request an EIOD when:

   1. The Member or practitioner believes that waiting for a decision under the standard timeframe could place the Member's life, health, or ability to regain maximum function in serious jeopardy; and

   2. The Member believes the Health Plan should furnish directly or arrange for services to be provided (when the Member has not already received the services outside of the Health Plan).

C. EIODs may not be requested for cases in which the only issue involves claims payment for services the Member has already received.

D. The 72-hour timeframe for a determination regarding the requested service(s) commences when the Utilization Management department receives the request for an EIOD.

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

F. For a request made by a Member or applicable representatives, IEHP must expedite the review of a determination if IEHP finds that applying the standard timeframe may jeopardize the Member's health, life, or ability to regain maximum function.

G. If clinical information is needed from a non-contracted practitioner, IEHP will request this information within 24 hours of the initial request for an EIOD. Non-contracted practitioners must make reasonable and diligent efforts to expeditiously gather and

forward all necessary information to assist in meeting the required time frame. Regardless of whether IEHP must request clinical information from non-contracted practitioners, IEHP is still responsible for meeting the same timeframe and notification requirements for EIODs.

H. If it is determined that the Member's condition does not warrant an expedited determination, the Member will be verbally notified within 72 hours of receipt of the request (includes weekends and holidays) followed by written notification within three (3) calendar days of the verbal notification. The request will automatically be processed within the standard timeframe of 14 calendar days for a determination beginning the day the request was received for an EIOD. The Expedited Criteria Not Met notice (see Attachments 14-9a and 14-9b in Section 14, "Attachments") must:

1. Explain that the request will be processed using the 14-calendar day timeframe for standard determinations;
2. Inform the Member of the right to file an expedited grievance if he or she disagrees with the decision to not expedite the determination, give instructions for filing an expedited grievance; give the expedited grievance process timeframe, and an explanation of the criteria for expedited reviews;
3. Inform the Member of the right to resubmit a request for an EIOD if the Member gets any practitioner's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function. The request will be expedited automatically; and
4. Provide instructions about the expedited grievance process and its timeframes.

I. If the request is approved for an EIOD, the determination must be made in accordance with the following requirements:

1. Whether the decision is to approve, modify, or deny, the Member and practitioner must be notified of the decision within 72 hours of receipt of the request.
2. If the initial notification to the Member of the expedited determination is verbally, then written notification to the Member must occur within three (3) calendar days of the verbal notification.
3. If only written notification is given for a modification or denial determination, the Member and practitioner must receive the notification within 72 hours of receipt of the EIOD request.

J. Written communication regarding a modification or denial must be written in a manner that is understandable and sufficient in detail so that the Member and practitioner can understand the rationale for the decision. The Notice of Denial of Medical Coverage

(NDMC) letter (see Attachments 14-13a and 14-13b in Section 14, "Attachments") must include:

1. The specific reason for the denial that takes into account the Member's presenting medical condition, disabilities, and if any, special language requirements.
2. The determination is based upon Medicare Coverage Guidelines.
3. Information regarding the Member's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the Member's behalf.
4. A description of both the standard and expedited reconsideration processes that include conditions for obtaining an expedited reconsideration, and the other elements of the appeals process.
5. The Member's right to submit additional evidence in writing or in person.

K. An extension of no more than fourteen (14) calendar days may be allowed to perform the review under the following circumstances:

1. There is justification for additional information, (e.g., allowing for additional diagnostic procedures or specialty consultations) and there is documentation on how this delay is in the interest of the Member.
2. The Member or practitioner requests an extension of time to provide IEHP with additional information.
3. The practitioner requesting the EIOD is not contracted and the clinical information necessary to make the determination is not submitted within 72 hours.

L. Extensions must not be used to pend organization determinations while waiting for medical records from contracted providers.

M. The Member will be notified in writing of the reason for the delay, utilizing the Extension Needed for Additional Information – Expedited and Standard Initial Determination letter, (see Attachments 14-7a and 14-7b in Section 14, "Attachments") and informed of the right to file an expedited grievance (oral or written) if he or she disagrees with the decision for an extension. The written notification for the extension will include the clinical information needed, or the test or examination required.

N. A log must be maintained of all the EIOD requests received. The log must include all requests (oral and written), those processed as expedited, and those not meeting the expedited criteria. Timeframe and notification requirements are tracked on the log for those cases processed as expedited and for those cases not meeting expedited criteria (see Attachment 14-6 in Section 14, "Attachments").

O. All verbal notifications to Member and/or Provider will be documented with date and time.

H. Expedited Initial Organization Determinations (EIOD)

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Effective date:**	January 1, 2007
Chief Title: Chief Medical Officer	**Revised date:**	January 1, 2012

14. UTILIZATION MANAGEMENT

Attachments

ATTACHMENT	DESCRIPTION	POLICY CROSS REFERENCE
14-1	Request for UM Criteria	
	a. UM Criteria Letter	14A
	b. UM Criteria Log	14A
14-2	Referral Tracking Log	14B1a, 14C
14-3	Standing Referral/Extended Access Referral to Specialty Care Request Form	14B2
14-4	Second Opinion Tracking Log	14A, 14C
14-5	Specialty Office Service Authorization Sets	14E
14-6	Expedited Organization Determination Log	14H
	Medicare Letter Templates	
14-7	Extension Needed for Additional Information Letter	
	a. English	14A, 14H
	b. Spanish	14A, 14H
14-8	Detailed Explanation of Non-Coverage Letter (DENC)	
	a. English	14A, 14G
	b. Spanish	14A, 14G
14-9	Services Requested Do Not Meet Expedited Criteria Letter	
	a. English	14A, 14H
	b. Spanish	14A, 14H
14-10	Informational Letter to Beneficiary and/or PCP	
	a. English	14A
	b. Spanish	14A
14-11	Notice of Reinstatement of Coverage Letter	
	a. English	14A
	b. Spanish	14A
14-12	ICE UM Timeliness Standards – CMS	14A
14-13	Notice of Denial of Medical Coverage Letter (NDMC)	
	a. English	14A, 14G, 14H
	b. Spanish	14A, 14G, 14H
14-14	Notice of Medicare Non-Coverage Letter (NOMNC)	
	c. English	14A, 14G
	d. Spanish	14A, 14G
14-15	Detailed Notice of Discharge	
	a. English	14A, 14G
	b. Spanish	14A, 14G
14-16	Important Message from Medicare	14G

IEHP Medicare DualChoice HMO SNP

<Date>

<Name>
<Address>
<Address>

RE: Request for Utilization Management (UM) Criteria

Dear <Name>:

Attached is the clinical guideline or criteria used for determining health care services specific for the procedure or condition requested.

The materials provided to you are guidelines used by the plan to authorize, modify, or deny services for Members with a similar illness or condition. Specific care and treatment may vary depending on individual needs and the benefits covered under your health plan.

Sincerely,

<Utilization Management Department>

INLAND EMPIRE HEALTH PLAN

INLAND EMPIRE HEALTH PLAN
IEHP Medicare DualChoice HMO SNP
REQUEST FOR UM CRITERIA LOG

Submitted by: ___________________________________ Log for Year: _______________________________

Date Requested	Date Sent	Sent via: F = fax EM = email GM =ground mail	Name of the Requesting Practitioner or Member	Member Name and IEHP ID #	Line of Business (MC, HF, HK, DC)	Criteria Requested (i.e. InterQual-MRI Brain)	Reason for Request

Legend:

F = Fax
EM = email
GM = Ground

MC = Medi-Cal
HF = Healthy Families
HK = Healthy Kids

-DC = IEHP Medicare DualChoice HMO SNP

INLAND EMPIRE HEALTH PLAN

IEHP Medicare DualChoice HMO SNP
Referral Tracking Log

Date Referral Sent to IEHP	Member Name & IEHP ID Number	Acuity of Referral*	Reason for Referral/DX	Service/Activity Requested	Date Rec'd from IEHP	Referral Decision**	Date Patient Notified	Date of Appt/Service	Date Consult Report Rec'd

**Acuity of Referral: Emergent, Urgent, or Routine*
***Decision: Approved, Modified, or Denied*

INLAND EMPIRE HEALTH PLAN

INLAND EMPIRE HEALTH PLAN
IEHP Medicare DualChoice HMO SNP
SECOND OPINION TRACKING LOG

Date Submitted: ______________________________

Report for Month of: ______________________________ Submitted by: ______________________________

Member Name and IEHP ID #	Name of the Requesting Practitioner or Member	Diagnosis	Reason for Second Opinion *(use codes below)*	Request Date	Decision Date	Decision Code (circle one)	Second Opinion to be provided by (name):	Date of Appoint.	Date Consult Report Received	*See Legend Below For Member Type
						Approved Modified Denied				
						Approved Modified Denied				
						Approved Modified Denied				
						Approved Modified Denied				

Second Opinion Reason Codes:

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

Reason 2: The Member questions a diagnosis or plan or care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment including but not limited to a serous chronic condition.

Reason 3: If clinical indications are not clear or are complex and confusing, a diagnosis is questionable due to conflicting test results, or the treating PCP/Specialist is unable to diagnose the condition and the Member requests an additional diagnosis.

Reason 4: If the treatment plan in progress is not improving the medical condition of the Member within an appropriate time period given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment.

Reason 5: The Member has attempted to follow the plan of care or consulted with the initial physician concerning serious concerns about the diagnosis or plan of care.

Legend: MC = Medi-Cal
HF = Healthy Families
HK = Healthy Kids
DC = IEHP Medicare DualChoice HMO SNP

INLAND EMPIRE HEALTH PLAN

IEHP Medicare DualChoice HMO SNP
SPECIALTY OFFICE SERVICE AUTHORIZATION SETS

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

Procedure	CPT Code
Allergy - Skin Testing for 80 or Fewer Tests	95004 X up to 80
CARD – EKG (Adult & Peds)	93000
CARD – Routine Stress Treadmill (Adult)	93015
CARD – Holter Monitor (Adult & Peds)	93235
CARD – Echocardiogram (Peds only)	93303 or 93307 + 93320 + 93325
DERM – Punch Biopsy	11100
DERM – Cryotherapy of Lesions	17000, 17003, 17110
DERM – Excision of Nail & Nail Matrix	11750
NEURO - EEG Standard	95816 or 95819
ENDO – Urinalysis	81003 or 82947
ENDO – Glucose	82947
ENT – Tympanogram	92567
ENT – Pure Tone Audiogram	92557, 92582
ENT – Cerumen Removal	69210
ENT – Nasal Cauterization Treatment of Epistaxis (Anterior or Posterior)	30901,30905
ENT – Nasal Endoscopy	31231, 31238
ENT – Removal of Foreign Body Ear or Nose	69200, 30300
ENT – Streptococcus A Screen	87880
Gastroenterology – Flex Sigmoidoscopy	45330
GYN – Urine Pregnancy Test	81025

Procedure	**CPT Code**
GYN – Depo-Provera	X6051
GYN – Abnormal Pap Follow-Ups *and:*	99213-99215 (X 3)
Colposcopy with Biopsy	57452 or 57454-455, 57460
Endomentrial Biopsy	58100, 58558
LEEP	57460
Hematology - Bone Marrow Bx and/or Aspiration	38221, 38220
Orthopedics – Total Fracture Care (Watch for CCS) X 6 mos.	By site of injury By date of service
Orthopedics – X-Rays, in office simple extremity	73000-73140
Orthopedics – Casting, Splints	
Orthopedics – DME (boot, shoe, crutches)	
Orthopedics – Joint aspiration	20600-20615
Orthopedics – Trigger point injections	
Injection of Tendon & Ligament	20550-20553
Podiatry – Matrixectomy	11750
Podiatry – Debridement of Nails	11720-11721
Pulmonary – Spirometry	94010, 94060
Radiology - Mammogram	76092
- Breast Ultrasound @ radiologist suggestion	76645
- Cone View	76090
Rheumatology – T.P Injection	20552
Rheumatology – Injection of Tendon & Ligament	20550-20553
Rheumatology – Joint Aspiration	20600-20615
Surgery – Breast Biopsy	76095
Surgery – I & D of Cutaneous Abscess	10060-10061
Urology – UA	81000-81003
Urology - Cystoscopy	52000

INLAND EMPIRE HEALTH PLAN

IEHP Medicare DualChoice HMO SNP
EXPEDITED ORGANIZATION DETERMINATION TRACKING LOG

Date Submitted: ______________________________

Report for Month of: ______________________________________ **Submitted by:** ________________________________

Case ID #	Date/Time Request Received	Member Name and Member ID #	Service Requested	Meets Criteria* Yes/No	Date/Time of Expedited Decision	Date/Time of Oral Notice	Date of Written Notice	Extension [Yes/No] Date Written Notice	Decision Approve Modify Deny	Date/Time of Oral Notice Date of Written Notice

* **Expedited Review Criteria:** Time sensitive situations in which the standard timeframe for issuing a determination could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.

P.O BOX 19026, San Bernardino, CA 92423-9026
Tel 1-877-273-IEHP (4347) TTY 1-800-718-IEHP (4347) Fax (909) 890-5751
8:00 AM to 8:00 PM (PST), 7days a week, including holidays.

[Date]

[Name of Beneficiary or Representative]
[Address]

Beneficiary’s name:	Provider Name:
Member ID #:	Requested Service:
Health Plan Name:	[Date of Standard Request:]
[Health Plan Phone #:]	[Date of Expedited Request:]
Attending Physician’s Name:	[Time of Expedited Request:]

Dear [Beneficiary’s Name]:

This correspondence is in response to you or your physician’s request for an [expedited seventy-two (72) hour-delete if not applicable] initial decision regarding the services noted above. We need to extend our review past the [72-hour or 14 calendar day] timeframe.

In the case of your request, a [insert #] calendar day extension is required because:

OPTION 1: You or your physician requested an extension so that additional information could be obtained. [Medicare Advantage Organization (MAO) or its delegated provider group must explain how the need for this additional information is justified and in the interest of the member.]

OPTION 2: We believe that we may be able to approve the request with the additional information that is being requested. [Medicare Advantage Organization (MAO) or its delegated provider group must explain how the need for this additional information is justified and in the interest of the member. For example, the receipt of additional medical evidence from non-contracted providers or additional tests may change an MAO’s or provider group’s decision to deny.]We may not extend your [expedited seventy-two (72) hour-delete if not applicable] request by more than fourteen (14) additional calendar days from the date of the

expedited or standard request.

During this extension, [insert description of what the beneficiary must do in lay terms] ____

____

____

You may file an expedited oral or written grievance with your health plan if you disagree with our decision to delay its determination. The grievance process allows a member to file a complaint with the health plan about issues other than denied claims or services. Your health plan must respond to an expedited grievance within twenty-four (24) hours of receipt. To file an expedited grievance, you or your authorized representative should telephone, mail or fax your grievance to:

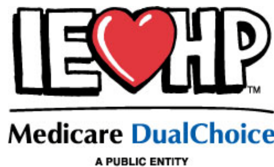
Inland Empire Health Plan
P.O. Box 19026
San Bernardino, CA 92423-9026
Toll Free: 1-877-273-IEHP (4347)
Fax: 909-890-2168
TTY: 1-800-718-4347

We will continue to make every effort to obtain the necessary information as soon as possible in order to complete the [expedited, delete if not applicable] review of this matter. If you have any questions, please call IEHP Member Services at 1-877-273-IEHP (4347) or 1-800-718-4347 TTY during the business hours of 8:00 am to 8:00 pm (PST), 7 days a week, including holidays.

Sincerely,

Name
Title

Cc: Provider, if provider requested



P.O BOX 19026, San Bernardino, CA 92423-9026
Tel 1-877-273-IEHP (4347) TTY 1-800-718-IEHP (4347) Fax (909) 890-5751
8:00 AM to 8:00 PM (PST), 7 días a la semana, incluyendo días festivos.

[Date]

[Name of Beneficiary or Representative]
[Address]

Nombre del beneficiario:
Número de identificación del afiliado:
Nombre del plan de salud:
[N° de teléfono del plan de salud:]
Nombre del médico tratante:

Nombre del proveedor:
Servicio solicitado:
[Fecha de la solicitud normal:]
[Fecha de la solicitud expedita:]
[Hora de la solicitud expedita:]

Estimado(a) [Beneficiary's Name]:

Esta carta tiene como finalidad responder a una solicitud de usted o de su médico para una decisión inicial [expedita de setenta y dos (72) horas-delete if not applicable) sobre el servicio indicado anteriormente. Necesitamos prolongar nuestra revisión pasado el plazo de [72 horas or 14 días calendario].

En el caso de su solicitud, se requiere una extensión de [insert #] días calendario debido a:

OPCIÓN 1: Usted o su médico solicitó una extensión a fin de que se pueda obtener dicha información adicional. [Medicare Advantage Organization (MAO) or its delegated provider group must explain how the need for this additional information is justified and in the interest of the member.]

OPCIÓN 2: Creemos que podríamos aprobar la solicitud con la información adicional que se solicita. [Medicare Advantage Organization (MAO) or its delegated provider group must explain how the need for this additional information is justified and in the interest of the member. For example, the receipt of additional medical evidence from non-contracted providers or additional tests may change an MAO's or provider group's decision to deny.]

No podemos prolongar su solicitud [expedita de setenta y dos (72) horas-delete if not applicable] en más de catorce (14) días calendario adicionales a partir de la fecha de la solicitud normal o expedita.

Durante esta extensión, [insert description of what the beneficiary must do in lay terms] ____

____

____

Puede presentar una queja formal expedita oral o por escrito ante su plan de salud si no está de acuerdo con nuestra decisión de retrasar su determinación. El proceso de queja formal le permite a un afiliado presentar una reclamación ante su plan de salud con respecto a asuntos aparte de reclamaciones o servicios rechazados. Su plan de salud debe responder a una queja formal expedita en un plazo de veinticuatro (24) horas a partir de la fecha en que se recibe. Para presentar una queja formal expedita, usted o su representante autorizado deben llamar por teléfono, o enviar por mail o fax su queja formal a:

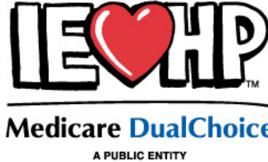
Inland Empire Health Plan
P.O. Box 19026
San Bernardino, CA 92423-9026
Línea gratuita: 1-877-273-IEHP (4347)
Fax: 909-890-2168
TTY: 1-800-718-4347
Horario de atención: De 8 a.m. a 8 p.m., los 7 días de la semana, incluidos los festivos

Continuaremos haciendo todo lo posible para obtener la información necesaria a la brevedad a fin de completar la revisión [expedita, delete if not applicable] de este asunto. Si tiene alguna pregunta o desea mayor información, llame al Servicio al Cliente de IEHP al 1-877-273-IEHP (4347) ó al 1-800-718-4347 TTY, de 8 a.m. a 8 p.m., los 7 días de la semana, incluidos los festivos.

Atentamente,

Name
Title

Cc: Proveedor, si lo solicita



P.O BOX 19026, San Bernardino, CA 92423-9026
Tel 1-877-273-IEHP (4347)   TTY 1-800-718-IEHP (4347)   Fax (909) 890-5528
8:00 AM to 8:00 PM (PST), 7days a week, including holidays.

Detailed Explanation of Non-coverage

Date:

Patient name: Patient number:

This notice gives a detailed explanation of why your Medicare health plan and/or provider has determined Medicare coverage for your current services should end. ***This notice is not the decision on your appeal.*** The decision on your appeal will come from your Quality Improvement Organization (QIO).

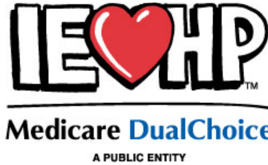
We have reviewed your case and decided that Medicare coverage of your current {insert type} services should end.

- **The facts used to make this decision:**

- **Detailed explanation of why your current services are no longer covered under your plan, and the specific Medicare coverage rules and policy used to make this decision:**

- **Plan policy, provision, or rationale used in making the decision:**

If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at: IEHP Medicare DualChoice (HMO SNP) at 1-877-273-IEHP (4347), 8:00 am to 8:00 pm, PST, 7 days a week, including holidays. TTY/TDD users should call 1-800-718-4347.



P.O BOX 19026, San Bernardino, CA 92423-9026
Tel 1-877-273-IEHP (4347) TTY 1-800-718-IEHP (4347) Fax (909) 890-5528
8:00 AM to 8:00 PM (PST), 7 días a la semana, incluyendo días festivos.

Explicación Detallada de Terminación de la Cobertura

Fecha:

Nombre del paciente: Número de identificación del paciente:

Este aviso le brinda una explicación detallada del motivo por el cual, su plan de salud de Medicare y/o su proveedor han determinado que la cobertura de Medicare de su servicios debe terminar. ***Esta notificación no es la decisión sobre su apelación.*** La decisión sobre su apelación provendrá de la Organización para el Mejoramiento de la Calidad (QIO por su sigla en inglés).

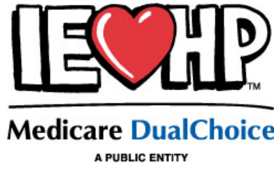
Hemos evaluado su caso y decidimos que la cobertura de Medicare de su servicios {insert type} actuales debe terminar.

- **Para tomar esta decisión nos hemos basado en:**

- **Explicación detallada del motivo por el cual sus servicios actuales ya no serán cubiertos por su plan, y sobre las normas y política de Medicare utilizadas para tomar esta decisión:**

- **Política, normas y razón del plan utilizadas para tomar la decisión:**

Si desea una copia de la política o normas usadas para tomar la decisión, o una copia de los documentos que se enviaron a la QIO, llámenos al: IEHP Medicare DualChoice (HMO SNP) al 1-877-273-IEHP (4347) o para usarios de TTY/TDD al 1-800-718-4347, de 8:00 a.m. a 8:00 p.m., los 7 días de la semana, incluidos los días festivos.



IEHP Medicare DualChoice HMO SNP
P.O BOX 19026, San Bernardino, CA 92423-9026
Tel 1-877-273-IEHP (4347) TTY 1-800-718-IEHP (4347) Fax (909) 890-5751
8:00 AM to 8:00 PM (PST), 7 days a week, including holidays.

[*Date*]

[*Name of Patient]*	*Patient* Name:
[*or Representative*]	*Patient* ID #:
[*Address*]	Health Plan Name:
	Health Plan Phone #:
	Provider Name:
	Requested Service:
	Date and Time of Expedited Request:
	Attending Physician's Name:

Dear [*Patient's Name*]:

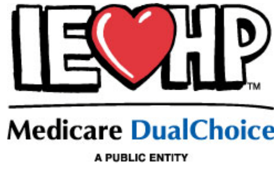
This correspondence is in response to your request for an expedited seventy-two (72) hour initial decision to approve the services noted above.

We have reviewed your request and based on the information available, have determined that your request does not meet the Centers for Medicare and Medicaid Services (CMS) definition of "time sensitive". We are required to complete our review of your request on an expedited basis if (1) your request meets the definition of "time sensitive"; or (2) a physician supports your request for an expedited review. Time sensitive is defined as "A situation where the time frame of the standard decision making process could seriously jeopardize the life or health of the enrollee, or could jeopardize the enrollee's ability to regain maximum function." Since your request has not met either of these two criteria, it has been forwarded to the standard review process.

We will make every effort to process your request as soon as possible but no later than fourteen (14) calendar days after the date of receipt of your request, and you will be notified once your review has been completed.

You have the right to resubmit a request for an expedited seventy-two (72) hour initial decision. If any physician supports your request for an expedited review, and the physician indicates that waiting for fourteen (14) days could seriously harm your health, the request will be expedited automatically.

You may also file an expedited oral or written grievance with your health plan regarding our decision not to expedite your review. The grievance process allows a member to file a complaint with their health plan about issues other than denied claims or services. Your health plan must respond to an expedited grievance within twenty-four (24) hours.



IEHP Medicare DualChoice HMO SNP
P.O BOX 19026, San Bernardino, CA 92423-9026
Tel 1-877-273-IEHP (4347) TTY 1-800-718-IEHP (4347) Fax (909) 890-5751
8:00 AM to 8:00 PM (PST), 7 days a week, including holidays.

To file an expedited grievance, you or your authorized representative should telephone, mail or fax your written grievance to:

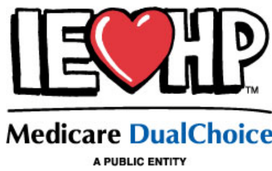
[Health Plan Name]
Attention:
[Address]
Telephone Number: ( )
TDD/TTY Number ( )
Fax Number: ( )

Also, please note that although you are not required to submit additional information to us, it is important you contact us immediately if your medical condition changes or if you have additional information pertinent to this matter.

Please direct any further questions or information to my attention at 1-(XXX)-XXX-XXXX or TDD/TTY (XXX)-XXX-XXXX between the hours of [*add the hours of operation]*.

Sincerely,

____
Name
Title



IEHP Medicare DualChoice HMO SNP
P.O BOX 19026, San Bernardino, CA 92423-9026
Tel 1-877-273-IEHP (4347)   TTY 1-800-718-IEHP (4347)   Fax (909) 890-5751
8:00 AM to 8:00 PM (PST), 7 días a la semana, incluyendo días festivos.

[Date]

[Name of Beneficiary]	Nombre del beneficiario:
[or Representative]	Nº de identificación del beneficiario:
[Address]	Nombre del plan de salud:
	N° de teléfono del plan de salud:
	Nombre del proveedor:
	Servicio solicitado:
	Fecha y hora de la solicitud expedita:
	Nombre del médico tratante:

Estimado(a) [Beneficiary's Name]:

Esta carta tiene como finalidad responder a una solicitud inicial expedita de setenta y dos (72) horas para aprobar los servicios indicados anteriormente.

Hemos revisado su solicitud y, basándonos en la información disponible, hemos determinado que su solicitud no cumple la definición de "apremiante" de los Centros para Servicios Medicare y Medicaid (CMS, por sus siglas en inglés). Se nos exige completar la revisión de su solicitud de manera expedita si (1) su solicitud cumple la definición de "apremiante" o (2) un médico apoya su solicitud de revisión expedita. Apremiante se define como "una situación en la cual el plazo normal del proceso de toma de decisión pondría en grave peligro la vida o la salud del beneficiario, o pondría en peligro la capacidad del beneficiario para recuperar su máxima función". Debido a que su solicitud no cumple ninguno de estos dos requisitos, se envió a un proceso de revisión normal.

Haremos todo lo posible para procesar su solicitud lo antes posible, en un plazo no superior a catorce (14) días calendario a partir de la fecha de recepción de su solicitud y se le informará una vez que la revisión se complete.

Tiene derecho a enviar nuevamente una solicitud para una decisión inicial expedita de setenta y dos (72) horas. Si algún médico respalda su solicitud para una revisión expedita e indica que esperar catorce (14) días perjudicaría seriamente su salud, la solicitud será automáticamente considerada expedita.

También puede presentar una queja expedita oral o por escrito ante su plan de salud con respecto a nuestra decisión de no hacer expedita su revisión. El proceso de queja formal le permite a un afiliado presentar una reclamación ante su plan de salud con respecto a asuntos aparte de reclamaciones o servicios denegados. Su plan de salud debe responder a una queja formal expedita en un plazo de veinticuatro (24) horas.

Para presentar una queja formal expedita, usted o su representante autorizado debe llamar por teléfono, o enviar por mail o fax su queja formal escrita a:

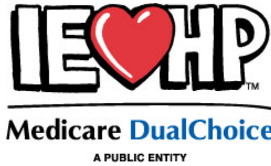
Inland Empire Health Plan
P.O. Box 19026
San Bernardino, CA 92423
Línea gratuita: 1-877-273-IEHP (4347)
TTY: 1-800-718-4347
Fax: 1-909-2168

También tenga presente que, aunque no se le exige enviarnos información adicional, es importante que se comunique con nosotros inmediatamente si su estado de salud cambia o si tiene información adicional relacionada con este asunto.

Si tiene alguna pregunta o desea mayor información, llame al Servicio al Cliente de IEHP al 1-877-273-IEHP (4347) o al 1-800-718-4347 TTY, de 8 a.m. a 8 p.m., los 7 días de la semana, incluidos los festivos.

Atentamente,

Nombre
Cargo



P.O BOX 19026, San Bernardino, CA 92423-9026
Tel 1-877-273-IEHP (4347)   TTY 1-800-718-IEHP (4347)   Fax (909) 890-5751
8:00 AM to 8:00 PM (PST), 7 days a week, including holidays.

[*Date*]

[*Name of Patient or Representative*]	Patient Name:
[*Address*]	Patient ID#:
	Health Plan Name:
	Attending Physician's Name:
	Requested Service:

Dear [*Patient Name*]:

This is **NOT** a denial of service. This notice is to inform you that [*insert provider organization name*], under contract with [*insert Health Plan name*], is not responsible for providing or authorizing the above requested service(s). Your health plan has contracted with [*insert name of carve out provider, i.e. VSP*] to provide this service.

Your request does not have to be re-submitted for you to receive this service. It can be arranged by you directly without prior authorization by contacting *[name of entity responsible for carved-out service*] at telephone number [*telephone number of responsible entity*] or TDD/TTY number [*TDD/TTY number*] during the hours [*insert hours available*].

If you have any questions, please contact your health plan, [*insert Health Plan name*] at **X-XXX-XXX-XXXX** or TTY/TDD at **X-XXX-XXX-XXXX,** between the hours [*insert hours available*] for further assistance regarding the requested service(s).

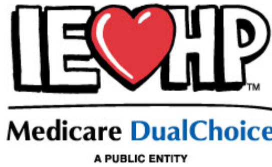
Sincerely,

____

Provider Organization Representative

[Insert all that apply]:

C: Patient File
Requesting Physician
PCP
Health Plan



P.O BOX 19026, San Bernardino, CA 92423-9026
Tel 1-877-273-IEHP (4347) TTY 1-800-718-IEHP (4347) Fax (909) 890-5528
8:00 AM to 8:00 PM (PST), 7 days a week, including holidays.

Notice of Reinstatement of Coverage

Date:___________ **Patient Name:**________________

Provider/Facility______________________ **Health Plan:**__________________

Service Start/Admission Date:_______________ **Member ID:**___________________

Attending Physician:______________________ **Address:**______________________

Type of Service:

☐ **Skilled Nursing**
☐ **Home Health**
☐ **Comprehensive Outpatient Rehabilitation**

Dear (insert: Member's Name):

On {insert: date} you received a Notice of Medicare Non-Coverage indicating the above services would end effective {insert: date} and that you would have to pay for any services you receive after that date.

This Reinstatement Notice is to inform you that upon further review, it has been determined that the above services shall continue with no lapse in coverage until further notice.

You will receive a new Notice of Medicare Non-Coverage indicating when your coverage will end, when it has been determined that you no longer require the above services.

If you have any questions regarding this Reinstatement Notice, please contact {insert: Health Plan/ Provider Organization} at (X-XXX-XXX-XXXX) or TTY/TDD at (X-XXX-XXX-XXXX) {insert: days of operation} between the hours of (insert: hours).

Sincerely,

(Health Plan or Provider Organization Designee)

IEHP Medicare DualChoice HMO SNP
Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

Type of Request	Decision	Notification Timeframes
Standard Initial Organization Determination (Pre-Service) - If No Extension Requested or Needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Within 14 calendar days after receipt of request. ▪ Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
Standard Initial Organization Determination (Pre-Service) - If Extension Requested or Needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	▪ Use the MA-Extension: Standard & Expedited to notify member and provider of an extension. ***<u>Extension Notice:</u>*** ▪ Give notice **in writing** within 14 calendar days of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The Health Plan must respond to an expedited grievance within 24 hours of receipt. ***<u>Decision Notification After an Extension:</u>*** ▪ Must occur no later than expiration of extension. Use NDMC template for written notification of denial decision.
Expedited Initial Organization Determination **-** If Expedited Criteria are not met	Promptly decide whether to expedite – determine if: 1) Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or 2) If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision. If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request	If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice. ▪ Use the MA Expedited Criteria Not Met template to provide written notice. The written notice must include: 1) Explain that the Health Plan will automatically transfer and process the request using the 14-day timeframe for standard determinations; 2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination; 3) Inform the member of the right to resubmit a request for an expedited determination

IEHP Medicare DualChoice HMO SNP
Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

Type of Request	Decision	Notification Timeframes
	to the standard timeframe. ▪ The 14 day period begins with the day the request was received for an expedited determination.	and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically; and 4) Provide instructions about the expedited grievance process and its timeframes.
Expedited Initial Organization Determination - If No Extension Requested or Needed (See footnote)[1]	As soon as medically necessary, within 72 hours after receipt of request (includes weekends & holidays).	Within 72 hours after receipt of request. ▪ **Approvals** – Oral or written notice must be given to member and provider within 72 hours of receipt of request. – Document date and time oral notice is given. – If written notice **only** is given, it must be **received** by member and provider within 72 hours of receipt of request. ▪ **Denials** – When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be **received** by member and provider within 72 hours of receipt of request. – Use NDMC template for written notification of a denial decision.

[1] Note: Health Plans may have referral requirements that may impact timelines. When processing expedited requests, groups must factor in the time it may take to refer the request to the health plan in the total 72 hours to ensure that expedited requests are handled timely.

IEHP Medicare DualChoice HMO SNP
Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

Type of Request	**<u>Decision</u>**	**Notification Timeframes**
Expedited Initial Organization Determination **-** If Extension Requested or Needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	▪ Use the MA-Extension: Standard & Expedited template to notify member and provider of an extension. ***<u>Extension Notice:</u>*** ▪ Give notice **in writing,** within 72 hours of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The Health Plan must respond to an expedited grievance within 24 hours of receipt. ***<u>Decision Notification After an Extension:</u>*** ▪ **<u>Approvals</u>** – Oral or written notice must be given to member and provider no later than upon expiration of extension. – Document date and time oral notice is given. – If written notice **only** is given, it must be **received** by member and provider no later than upon expiration of the extension. ▪ **<u>Denials</u>** – When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be **received** by member and provider no later than upon expiration of extension. – Use NDMC template for written notification of a denial decision.

IEHP Medicare DualChoice HMO SNP
Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
Hospital Discharge Appeal Notices (Concurrent)	Attending physician must concur with discharge decision from inpatient hospital to any other level of care or care setting. Continue coverage of inpatient care until physician concurrence obtained. Hospitals are responsible for valid delivery of the revised Important Message from Medicare (IM): 1) within 2 calendar days of admission to a hospital inpatient setting. 2) not more than 2 calendar days prior to discharge from a hospital inpatient setting. Health Plans or delegates are responsible for delivery of the Detailed Notice of Discharge (DND) when a member appeals a discharge decision. DND must be delivered as soon as possible but no later than noon of the day after notification by the QIO (Quality Improvement Organization).	Hospitals must issue the IM within 2 calendar days of admission, obtain the signature of the member or representative and provide a copy of the IM at that time. Hospitals must issue a follow up IM not more than 2 calendar days prior to discharge from an inpatient hospital. ▪ NOTE: Follow up copy of IM is not required: ▪ If initial delivery and signing of the IM took place within 2 calendar days of discharge. ▪ When member is being transferred from inpatient to inpatient hospital setting. ▪ For exhaustion of Part A days, when applicable. If IM is given on day of discharge due to unexpected physician order for discharge, member must be given adequate time (at least several hours) to consider their right to request a QIO review.	Upon notification by the QIO that a member or representative has requested an appeal, the Health Plan or delegate must issue the DND to both the member and QIO as soon as possible but no later than noon of the day after notification by the QIO. The DND must include: ▪ A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered. ▪ A description of any applicable Medicare coverage rules, instructions, or other Medicare policy, including information about how the member may obtain a copy of the Medicare policy from the MA organization. ▪ Any applicable Medicare health plan policy, contract provision, or rationale upon which the discharge determination was based. ▪ Facts specific to the member and relevant to the coverage determination sufficient to advise

IEHP Medicare DualChoice HMO SNP
Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
			the member of the applicability of the coverage rule or policy to the member's case. ▪ Any other information required by CMS.

Type of Request	Decision	Notice of Medicare Non-Coverage (NOMNC) Notification	Detailed Explanation of Non-Coverage (DENC) Notification
Termination of Provider Services: ▪ **Skilled Nursing Facility (SNF)** ▪ **Home Health Agency (HHA)** ▪ **Comprehensive Outpatient Rehabilitation Facility (CORF)** NOTE: This process does not apply to SNF Exhaustion of Benefits (100 day limit).	The Health Plan or delegate is responsible for making the decision to end services no later than two (2) calendar days or 2 visits before coverage ends: ▪ Discharge from SNF, HHA or CORF services **OR** ▪ A determination that such services are no longer medically necessary	The SNF, HHA or CORF is responsible for delivery of the NOMNC to the member or authorized representative ▪ The NOMNC must be delivered no later than 2 calendar days or 2 visits prior to the proposed termination of services and must include: member name, delivery date, date that coverage of services ends, and QIO contact information. ▪ The NOMNC may be delivered earlier if the date that coverage will end is known. ▪ If expected length of stay or service is 2 days or less, give notice on admission. **Note**: Check with Health Plan or delegate for delegated responsibility, as a Health Plan or delegate may choose to deliver the NOMNC instead of the provider.	Upon notification by the Quality Improvement Organization (QIO) that a member or authorized representative has requested an appeal: ▪ The Health Plan or delegate must issue the DENC to both the QIO and member no later than close of business of the day the QIO notifies the Health Plan of the appeal.

Medicare DualChoice
A PUBLIC ENTITY

P.O BOX 19026, San Bernardino, CA 92423-9026
Tel 1-877-273-IEHP (4347) TTY 1-800-718-IEHP (4347) Fax (909) 890-5528
8:00 AM to 8:00 PM (PST), 7days a week, including holidays.

Notice of Denial of Medical Coverage

Date: **Member number:**

Beneficiary's name:

We have denied coverage of the following medical services or items that you or your physician requested:

____
____
____
____
____
____

We denied this request because:

____
____
____
____
____
____

What If I Don't Agree With This Decision?

You have the right to appeal. File your appeal in writing within 60 calendar days after the date of this notice. We can give you more time if you have a good reason for missing the deadline.

Who May File An Appeal?

You or your treating physician may file an appeal. Or you may name a relative, friend, advocate, attorney, doctor (other than your treating physician), or someone else to act as your representative. Others also already may be authorized under State law to act for you.

You can call us at: IEHP Member Services at 1-877-273-IEHP (4347), 8:00 a.m. to 8:00 p.m., 7 days a week, including holidays to learn how to name your representative.

If you have a hearing or speech impairment, please call us at TTY 1-800-718-4347.

If you want someone to act for you, you and your representative must sign, date, and send us a statement naming that person to act for you.

Important Information About Your Appeal Rights

There are two kinds of appeals you can file:

Standard (30 days) - You can ask for a standard appeal. We must give you a decision no later than 30 days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

Fast (72 hour review) - You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 30 days for a decision. We must decide on a fast appeal no later than 72 hours after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

- **If any doctor** asks for a fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, **we will automatically give you a fast appeal.**
- If you ask for a fast appeal without support from a doctor, we will decide if your health requires a fast appeal. We will notify you if we do not give you a fast appeal, and we will decide your appeal within 30 days.

What do I include with my appeal?
Your written request should include: your name, address, member number, reasons for appealing, and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person.

How Do I File An Appeal?

For a Standard Appeal: Mail or deliver your written appeal to the address below:

Inland Empire Health Plan
P.O. Box 19026
San Bernardino, CA 92423-9026

For a Fast Appeal: Contact us by telephone or fax:

Toll Free: 1-877-273-IEHP (4347)
TTY: 1-800-718-4347
Fax: 1-909-890-5748

What Happens Next?
If you appeal, we will review our decision. After we review our decision, if any of the services you requested are still denied, Medicare will provide you with a new and impartial review of your case by a reviewer outside of your Medicare health plan. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

Contact Information:
If you need information or help, call **us** at:
Toll Free: 1-877-273-IEHP (4347)
TTY: 1-800-718-4347

Other Resources to Help You:
Medicare Rights Center:
Toll Free: 1-888-HMO-9050
Elder Care Locator
Toll Free: 1-800-677-1116
1-800-MEDICARE (1-800-633-4227)
TTY: 1-877-486-2048

Form CMS-10003-NDMC (Exp. 10/31/2013) OMB Approval 0938-0829

P.O BOX 19026, San Bernardino, CA 92423-9026
Tel 1-877-273-IEHP (4347) TTY 1-800-718-IEHP (4347) Fax (909) 890-5528
8:00 AM to 8:00 PM (PST), 7 días a la semana, incluyendo días festivos.

Aviso de Denegación de Cobertura Médica

Fecha: **Número de identificación del miembro:**

Nombre del beneficiario:

Le hemos denegado la cobertura de los siguientes servicios o artículos, solicitados por usted o su médico:

____
____
____
____
____

El pedido ha sido denegado porque:

____
____
____
____
____
____

¿Qué ocurre si no estoy de acuerdo con esta decisión?

Usted tiene derecho a apelar la decisión. Debe apelar la decisión por escrito en los 60 días siguientes a la fecha en la que recibe el aviso. Si tiene algún motivo importante que le impida cumplir con este plazo, podremos darle más tiempo.

¿Quién puede apelar?

Usted o el médico que lo trata puede apelar la decisión. También puede nombrar a un familiar, amigo, defensor, abogado, médico (que no sea el médico que lo trata) o cualquier otra persona que actúe en nombre suyo. Otras personas podrían estar autorizadas por la ley estatal para representarlo.

Usted puede llamarnos al: Servicios para Miembros de IEHP 1-877-273-IEHP (4347), de 8:00 a.m. a 8:00 p.m., hora del Pacifico, los 7 días de la semana, incluidos los días festivos, para averiguar cómo designar un representante.
Si tiene algún impedimento auditivo o del habla, llame al TTY/TTD 1-800-718-4347.

Si desea que alguien lo represente, usted y su representante deben enviarnos una declaración en la que se indique que lo ha nombrado como su representante, la misma debe estar firmada y fechada.

Información Importante sobre sus Derechos de Apelación

Hay dos tipos de apelación que puede solicitar:

Estándar (30 días)- Puede solicitar una apelación estándar, lo que significa que a los 30 días de recibir su pedido de apelación debemos informarle sobre nuestra decisión. (Este período podría extenderse hasta 14 días si usted pide una extensión, o si nosotros necesitamos más información y la extensión lo beneficia.)

Rápida (72 horas)- Puede solicitar una apelación acelerada si usted y/o su médico consideran que su salud podría estar en peligro si tiene que esperar 30 días hasta que se tome una decisión. En caso de una apelación acelerada se debe tomar una decisión a más tardar a las 72 horas de haber recibido su pedido de apelación. (Este período podría extenderse hasta 14 días si usted pide una extensión, o si necesitamos más información y la extensión lo beneficia.)

- **Si un médico** apela una decisión por usted, o lo apoya para que usted lo haga y manifiesta que si usted tiene que esperar 30 días su salud corre peligro, **nosotros le otorgaremos automáticamente una apelación rápida**.

- Si usted solicita una apelación rápida el apoyo de su médico, nosotros decidiremos si su estado de salud requiere que se le otorgue una apelación rápida. Si no se la otorgamos, se decidirá sobre su apelación en 30 días.

¿Qué debo incluir en mi apelación?
En su pedido de apelación por escrito debe incluir: su nombre, dirección, número de identificación, el motivo de su apelación y cualquier evidencia que quiera adjuntar. Puede enviar informes médicos, cartas del médico u otra información que contribuya a su caso. Si necesita este tipo de información, pídasela a su médico. Usted puede enviar la información por correo o entregarla en persona.

¿Cómo presento una apelación?

Apelación estándar: Usted puede enviarla por correo o entregarla en persona en la dirección(es) mencionada abajo:

Inland Empire Health Plan
P.O. Box 19026
San Bernardino, CA 92423-9026

Apelación rápida: Comuníquese con nosotros por teléfono o por fax:

Toll Free: 1-877-273-IEHP (4347)
TTY: 1-800-718-4347
Fax: 1-909-890-5748

¿Qué sucede después?
Si usted apela una decisión, nosotros evaluaremos el caso nuevamente. Si después de hacerlo, aún seguimos denegando el servicio, Medicare designará a una persona imparcial que no pertenezca al plan de salud de Medicare para que analice el caso. Si no está de acuerdo con dicha decisión, tendrá otros derechos de apelación que le serán notificados.

Contactos:
Si necesita información o ayuda, **llámenos** al
Número sin cargo: 1-877-273-IEHP (4347)
TTY: 1-800-718-4347

Otros recursos de ayuda:
Medicare Rights Center:
Número sin cargo: 1-888-HMO-9050

Elder Care Locator
Número sin cargo: 1-800-677-1116

1-800-MEDICARE (1-800-633-4227)
TTY: 1-877-486-2048

Formulario de CMS-10003-NDMC (SP) (Exp. 10/31/2013) Número de aprobación de OMB 0938-0829

Medicare DualChoice
A PUBLIC ENTITY

P.O BOX 19026, San Bernardino, CA 92423-9026
Tel 1-877-273-IEHP (4347) TTY 1-800-718-IEHP (4347) Fax (909) 890-5528
8:00 AM to 8:00 PM (PST), 7days a week, including holidays.

Notice of Medicare Non-Coverage

Patient name: **Patient number:**

The Effective Date Coverage of Your Current {insert type}
Services Will End: **{insert effective date}**

- Your Medicare health plan and/or provider have determined that Medicare probably will not pay for your current {insert type} services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above, neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than the effective date of this notice.
- Call your QIO at: Health Services Advisory Group, Inc. at 1-800-841-1602 (TTY/TDD: 1-800-881-5980) to appeal, or if you have questions.

See the back of this notice for more information.

Other Appeal Rights:

- If you miss the deadline for requesting an immediate appeal with the QIO, you still may request an expedited appeal from your Medicare Health plan. If your request does not meet the criteria for an expedited review, your plan will review the decision under its rules for standard appeals. Please see your Evidence of Coverage for more information.
- Contact your plan or 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048 for more information about the appeals process.

Plan Contact Information:

IEHP Medicare DualChoice (HMO SNP)
P.O. BOX 19026
San Bernardino, CA 92423-9026
1-877-273-IEHP (4347) For TTY/TDD: 1-800-718-IEHP (4347)
8:00 a.m. – 8:00 p.m. (PST), 7 days a week, including holidays.

Additional Information (Optional):

Please sign below to indicate you have received this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

______________________________________ __________________
Signature of Patient or Representative Date

Medicare DualChoice
A PUBLIC ENTITY
P.O BOX 19026, San Bernardino, CA 92423-9026
Tel 1-877-273-IEHP (4347) TTY 1-800-718-IEHP (4347) Fax (909) 890-5528
8:00 AM to 8:00 PM (PST), 7 días a la semana, incluyendo días festivos.

Notificación de Medicare de Terminación de Cobertura

Nombre del Paciente: **Número de ID del Paciente:**

La fecha en que comenzó la cobertura de los servicios de {insert type}
Los servicios terminarán el **{insert effective date}**

- Su plan Medicare o su proveedor ha determinado que Medicare probablemente no pagará por los servicios de {insert type} que usted está recibiendo, a partir de la fecha indicada arriba.
- Después de esa fecha, usted tendrá que pagar por cualquier servicio que reciba.

Su derecho a apelar esta decisión

- Usted tiene derecho a una revisión médica (apelación) inmediata e independiente de la decisión de terminar la cobertura de Medicare de los servicios. Usted continuará recibiendo los servicios hasta que se tome una decisión.
- Si apela la decisión, el revisor independiente le pedirá su opinión, también analizará su historial médico y otra información relevante. Usted no tendrá que preparar un informe escrito, pero si lo desea puede hacerlo.
- Si decide apelar, tanto usted como el revisor independiente recibirán una copia de la explicación detallada sobre el motivo por el cual la cobertura de los servicios no debe continuar. Usted recibirá esta explicación después de que haya presentado su pedido de apelación.
- Si decide apelar, y el revisor independiente coincide en que la cobertura de los servicios no debe continuar después de la fecha indicada arriba, ni Medicare ni su plan pagarán por dichos servicios a partir de esa fecha.
- Si usted deja de recibir los servicios a partir de la fecha indicada arriba, podrá evitarse cualquier responsabilidad económica.

Cómo solicitar una apelación inmediata

- Debe solicitársela a la Organización para el Mejoramiento de la Calidad (QIO por su sigla en inglés). La QIO es el revisor independiente autorizado por Medicare para evaluar la decisión de terminar estos servicios.
- Su solicitud de apelación inmediata debe hacerse tan pronto sea posible, pero a más tardar para el mediodía del día antes de la fecha de efectividad indicada arriba.
- La QIO le informará su decisión lo más pronto posible, por lo general dos días después de la fecha de efectividad de esta notificación.
- Llame a su QIO al: Health Services Advisory Group, Inc. at 1-800-841-1602 (Para usos de TTY/TDD: 1-800-881-5980) para apelar la decisión o si tiene preguntas.

Si desea más información vea el reverso de esta página

Otros derechos de apelación:

- Si se le pasa la fecha para solicitarle a su QIO una apelación inmediata, es posible que aún pueda solicitarle una apelación acelerada a su plan de salud de Medicare. Si su pedido no responde al criterio para una apelación acelerada, el plan considerará su solicitud como una apelación estándar. Para más información, consulte la Evidencia de Cobertura.
- Comuníquese con su plan o llame al 1-800-MEDICARE (1-800-633-4227), o al TTY: 1-877-486-2048 para obtener más información sobre el proceso de apelación.

Información para comunicarse con su plan:

IEHP Medicare DualChoice (HMO SNP)
P.O. BOX 19026
San Bernardino, CA 92423-9026
1-877-273-IEHP (4347) Para usos de TTY/TDD: 1-800-718-IEHP (4347)
8:00 a.m. – 8:00 p.m. (hora del Pacifico), los 7 días de la semana, incluidos los días festivos.

Información adicional (Opcional):

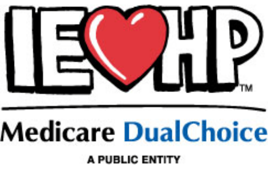
Por favor firme abajo para indicar que ha recibido esta notificación.

Se me ha informado que la cobertura de mis servicios terminará en la fecha indicada en esta notificación, y que puedo ponerme en contacto con mi QIO para apelar la decisión.

____________________________________ ________________
Firma del paciente o del representante Fecha

Patient Name:
Patient ID Number:
Physician:

OMB Approval No. 0938-1019
Date Issued:



IEHP Medicare DualChoice HMO SNP
P.O BOX 19026, San Bernardino, CA 92423-9026
Tel 1-877-273-IEHP (4347) TTY 1-800-718-IEHP (4347) Fax (909) 890-5528
8:00 AM to 8:00 PM (PST), 7 days a week, including holidays.

Detailed Notice Of Discharge

You have asked for a review by the Quality Improvement Organization (QIO), an independent reviewer hired by Medicare to review your case. This notice gives you a detailed explanation about why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on ______________________________ . This is based on Medicare coverage policies listed below and your medical condition.

This is not an official Medicare decision. The decision on your appeal will come from your Quality Improvement Organization (QIO).

- Medicare Coverage Policies:

  _____ Medicare does not cover inpatient hospital services that are not medically necessary or could be safely furnished in another setting. (Refer to 42 Code of Federal Regulations, 411.15 (g) and (k)).

  _____ Medicare Managed Care policies, if applicable: ____________________________ ____________________________ {insert specific managed care policies}

  _____ Other ____________________________ {insert other applicable policies}

- Specific information about your current medical condition:

- If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, please call ____________________________{insert hospital and/or plan telephone number}.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 1019. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Instructions for Completing the Detailed Notice of Discharge

CMS 10066

This is a standardized notice. Hospitals may not deviate from the content of the form except where indicated. Please note that the OMB control number must be displayed on the notice. Insertions must be typed or legibly hand-written in 12-point font or the equivalent.

Hospitals or plans may modify the following sections to incorporate use of a sticker or label that includes this information:

Patient Name: Fill in the patient's full name.

Patient ID number: Fill in the patient's ID number. This should not be, nor should it contain, the patient's social security or HICN number.

Physician: Fill in the name of the patient's physician.

Date Issued: Fill in the date the notice is delivered to the patient by the hospital/plan.

Insert logo here: Hospitals/plans may elect to place their logo in this space. However, the name, address, and telephone number of the hospital/plan must be immediately under the logo, if not incorporated into the logo. If no logo is used, the name and address and telephone number (including TTY) of the hospital/plan must appear above the title of the form.

BLANK 1: "**This notice gives you a detailed explanation of why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on ________________________________.** In the space provided, fill in planned date of discharge.

First Bullet: **"Medicare Coverage Policies:"** Place a check next to the applicable Medicare and/or managed care policies. If necessary, hospitals may also use the selection "Other" to list other applicable policies, guidelines or instructions. Hospitals or plans may also preprint frequently used coverage policies or add more space below this line, if necessary. Policies should be written in full sentences and in plain language. In addition, the hospital or plan may attach additional pages or specific policies or discharge criteria to the notice. Any attachments must be included with the copy sent to the QIO as well.

Second Bullet: **"Specific information about your current medical condition"** Fill in detailed and specific information about the patient's current medical condition and the reasons why services are no longer reasonable or necessary for this patient or are no longer covered according to Medicare or Medicare managed care coverage guidelines. Use full sentences and plain language.

Third Bullet: **"If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, please call _________________________________."** The hospital/plan should also supply a telephone number for patients to call to get a copy of the relevant documents sent to the QIO. If the hospital/plan has not attached the Medicare policies and/or the Medicare managed care plan policies used to decide the discharge date, the hospital should supply a telephone number for patients to call to obtain copies of this information.

Hospitals or plans may add space below this section to insert a signature line and date, if they so choose.

Nombre del paciente: Nº de aprobación OMB 0938-1019
Número de identificación del paciente: Fecha de emisión:
Médico:

P.O BOX 19026, San Bernardino, CA 92423-9026
Tel 1-877-273-IEHP (4347) TTY 1-800-718-IEHP (4347) Fax (909) 890-5528
8:00 AM to 8:00 PM (PST), 7 días a la semana, incluyendo días festivos.

Aviso Detallado Sobre Dado De Alta

Usted ha solicitado una revisión a la Organización para el Mejoramiento de la Calidad (QIO por su siglas en inglés), una organización independiente contratada por Medicare para revisar su caso. En este aviso se explica en detalle la razón por la que su hospital y el plan de cuidado de salud administrado (si pertenece a uno de ellos), de acuerdo con el médico, consideran que sus servicios de hospital como paciente interno (hospitalización) deben terminar el ______________________________ . Esto se basa en las políticas de cobertura de Medicare enumeradas a continuación y a su situación médica.

Esto no es una decisión oficial de Medicare. La decisión sobre la apelación provendrá de la Organización para el Mejoramiento de la Calidad (QIO).

- Políticas de cobertura de Medicare:

  _____ Medicare no cubre los servicios de hospital como paciente interno (hospitalización) que no son necesarios desde el punto de vista médico o que podrían brindarse de manera segura en otro lugar. (Refiérase al Código 42 de Regulaciones Federales, 411.15 (g) y (k)).

  _____ Políticas del cuidado de salud administrado de Medicare, si corresponde: ______________________________ (escribir las pautas de políticas específicas sobre el cuidado de salud administrado)

  _____ Otro ____________________ {escribir otras pautas de políticas aplicables}

- Información específica sobre su situación médica actual:

- Si desea una copia de los documentos enviados al QIO, o copias de las políticas o los criterios específicos utilizados para tomar esta decisión, favor de llamar a ______________________________{escribir el número de teléfono del hospital o del plan}.

De acuerdo con la Ley de Reducción de papaleo ("Paperwork Reduction Act) de 1995, no se exige a nadie que responda a la información solicitada a menos que se exhiba un número de control OMB válido. El número de OMB correspondiente a esta recolección de datos es el 0938-NEW. El tiempo promedio calculado para contestar las preguntas es un promedio de 60 minutos por respuesta, incluido el tiempo para leer las instrucciones, buscar reseñas de datos existentes, recopilar los datos necesarios, completar y revisar la información. Si tiene comentarios sobre el tiempo de respuesta o sugerencias para mejorar este formulario, favor de escribir a: CMS, Attn:: PRA Reports Clearance Officer, 7500 Security Boulevard, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Instrucciones para completar el aviso de salida (dado de alta)

CMS 10066

Este es un aviso estandarizado. Los hospitales no pueden apartarse del contenido del formulario con excepción de los casos en los que así se indique. Es importante saber que debe mostrar el número de control de OMB en el aviso. Las inserciones deben escribirse a máquina o a mano de manera legible en letra tamaño 12 o equivalente.

Los hospitales o los planes pueden modificar las siguientes secciones como modo de incluir el uso de un adhesivo o etiqueta con esta información:

Nombre del paciente: Escriba el nombre completo del paciente.
Número de identificación del paciente: Complete el número de identificación del paciente. No debe ser ni incluir el número de seguro social o HICN del paciente.
Médico: Escriba el nombre del médico del paciente.
Fecha de emisión: Fecha de entrega del aviso al paciente por el hospital o el plan.

Coloque la insignia o emblema aquí: Los hospitales o los planes pueden colocar la insignia o emblema en este espacio si así lo deciden. No obstante, el nombre, la dirección y el número de teléfono del hospital o el plan deben colocarse inmediatamente debajo del emblema, si no están ya incorporados dentro del emblema. Si no se usa una insignia, el nombre y la dirección y el número de teléfono (TTY también) del hospital o el plan deben aparecer encima del título del formulario.

Espacio En Blanco: **"En este aviso se explica en detalle la razón por la que su hospital y el plan de cuidado de salud administrado (si pertenece a uno de ellos), de acuerdo con el médico, consideran que sus servicios de hospital como paciente interno (hospitalización) deben terminar el ________________________________.** En el espacio suministrado, escriba la fecha prevista para la salida (dado de alta).

Punto No 1: **"Políticas de cobertura de Medicare":** Seleccione las políticas de Medicare o de cuidado de salud administrado aplicables. Si fuera necesario, los hospitales pueden usar también la selección "Otro" para enumerar otras políticas, pautas o instrucciones aplicables. Los hospitales o los planes también pueden imprimir con anterioridad las políticas de cobertura usadas frecuentemente o añadir más espacio debajo de este renglón, si fuera necesario. Las pautas políticas deben expresarse con oraciones completas y en lenguaje simple. Por otra parte, el hospital o el plan pueden incluir al aviso otras páginas, políticas específicas o criterios específicos sobre darse de alta. Cualquier anexo debe incluirse en la copia enviada al QIO.

Punto No 2: **"Información específica sobre su condición médica actual"** Complete con información detallada y específica sobre el problema médico actual del paciente y las razones por las que los servicios ya no son razonables o necesarios para este paciente o ya no están cubiertos de acuerdo con las pautas de cobertura de Medicare o del cuidado de salud administrado de Medicare. Use oraciones completas y lenguaje simple.

Punto No 3: **"Si desea una copia de los documentos enviados al QIO, o copias de las políticas o los criterios específicos utilizados para tomar esta decisión, favor de llamar a: ________________________________."** El hospital o el plan deben incluir también un número de teléfono para que llamen los pacientes como modo de obtener una copia de los documentos pertinentes enviados al QIO. Si el hospital o el plan no han adjuntando las políticas de Medicare o las políticas del plan de cuidado de salud administrado de Medicare que se usaron para escoger la fecha para darse de alta, el hospital deberá ofrecer un número de teléfono al que pueden llamar los pacientes para obtener copias de esta información.

Los hospitales o los planes pueden añadir espacio debajo de esta sección a fin de incluir un renglón para firmar e incluir la fecha, si así lo deciden.

Patient Name:
Patient ID Number:
Physician:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT, YOU HAVE THE RIGHT TO:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here: Health Services Advisory Group, Inc., Attention: Beneficiary Protection, 5201 W. Kennedy Boulevard, Suite 900, Tampa, FL 33609-1822 ; Phone: 1-800-841-1602 or TDD 1-800-881-5980; Fax: 866-800-8757.

YOUR MEDICARE DISCHARGE RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  - **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- **Step by step instructions for calling the QIO and filing an appeal are on page 2.**

To speak with someone at the hospital about this notice, call ___________________________.

Please sign and date here to show you received this notice and understand your rights.

____ __________________

Signature of Patient or Representative Date

STEPS TO APPEAL YOUR DISCHARGE

- **STEP 1**: You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  - Here is the contact information for the QIO:
    Health Services Advisory Group, Inc., Attention: Beneficiary Protection, 5201 W. Kennedy Boulevard, Suite 900, Tampa, FL 33609-1822; Phone: 1-800-841-1602 or TDD 1-800-881-5980; Fax: 866-800-8757.

  - You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun.**
  - Ask the hospital if you need help contacting the QIO.
  - The name of this hospital is______{insert the name of the hospital and the provider ID number}__.
- **STEP 2**: You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- **STEP 3**: The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
- **STEP 4**: The QIO will review your medical records and other important information about your case.
- **STEP 5**: The QIO will notify you of its decision within 1 day after it receives all necessary information.
  - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  - If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

IF YOU MISS THE DEADLINE TO APPEAL, YOU HAVE OTHER APPEAL RIGHTS:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call the QIO listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Additional Information:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information

collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Notice Instructions

The Important Message from Medicare (OMB #0938-0692) (CMS-R-193)

Completing the Notice

PAGE 1 of the Important Message from Medicare

A. Header

Hospitals must display "DEPARTMENT OF HEALTH & HUMAN SERVICES, Centers for Medicare & Medicaid Services" and the OMB number.

The following blanks must be completed by the hospital. Information inserted by hospitals in the blank spaces on the IM may be typed or legibly hand-written in 12-point font or the equivalent. Hospitals may also use a patient label that includes the following information:

Patient Name: Fill in the patient's full name.

Patient ID number: Fill in an ID number that identifies this patient. This number should not be, nor should it contain, the social security number.

Physician: Fill in the name of the patient's physician.

B. Body of the Notice

Bullet # 3 Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here ________________________.
Hospitals may preprint or otherwise insert the name and telephone number (including TTY) of the QIO.

To speak with someone at the hospital about this notice call: Fill in a telephone number at the hospital for the patient or representative to call with questions about the notice. Preferably, a contact name should also be included.

Patient or Representative Signature: Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents.

Date: Have the patient or representative place the date he or she signed the notice.

PAGE 2 of the Important Message from Medicare

First sub-bullet - Insert name and telephone number of QIO in BOLD: Insert name and telephone number (including TTY), in bold, of the Quality Improvement Organization that performs reviews for the hospital.

Second sub-bullet – The name of this hospital is: Insert/preprint the name of the hospital, including the Medicare provider ID number (not the telephone number).

Additional Information: Hospitals may use this section for additional documentation, including, for example, obtaining beneficiary initials to document delivery of the follow-up copy of the IM, or documentation of refusals.