14. UTILIZATION MANAGEMENT

A. Utilization Management Delegation and Monitoring

APPLIES TO:

A. This policy applies to all Healthy Families and Healthy Kids Members.

POLICY:

A. IEHP is responsible for the development, implementation, and distribution of standards for Utilization Management (UM) processes and activities to contracted Entities delegated to perform UM 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. IEHP delegates all or partial UM activities to contracted IPAs that meet IEHP UM standards with the exception of vision services and referrals for behavioral health.

E. All contracted Delegates must have a UM Plan, UM Policies and Procedures, and perform UM activities in a manner that meets IEHP, National Committee for Quality Assurance (NCQA), Department of Health Care Services (DHCS), and Department of Managed Health Care (DMHC) standards.

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

G. Delegates must have a Second Opinion process in place for Members requesting second opinions and submit a monthly log to IEHP (see Attachment 14-9 in Section 14, "Attachments").

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

I. IEHP maintains Benefit Manuals for each product line which outlines covered and non-covered services, procedures, and medical equipment.

PROCEDURE:

A. **UM Standards**: IEHP is responsible for defining overall standards for UM activities performed by contracted Delegates. These standards represent the minimum performance level acceptable to IEHP for Delegates; however, Delegates can choose to exceed any specific standard.

B. **Criteria:** Entities delegated to perform UM must use nationally recognized UM

standards when making decisions related to medical care. Criteria sets approved by IEHP include IEHP UM Subcommittee Approved Authorization Guidelines, Milliman Care Guidelines, InterQual, and Apollo Managed Care Guidelines/Medical Review Criteria. IEHP may distribute additional criteria following approval by the IEHP QM Committee.

1. **Development:** Criteria or guidelines that are developed by the Delegate or 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:** Delegates are required to apply criteria in a consistent and appropriate manner based on available medical information and the needs of individual Members. Delegates should ensure consistent application of UM Criteria by following this specific order:

    a. Check the Benefit/Guidelines for the Member's line of business.

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

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

    d. Check Apollo Medical Review 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. **Process for Obtaining Criteria:** Delegates must disclose to network practitioners, Members, or the public, upon request, the clinical guidelines or criteria used for determining health care services specific to the procedure or condition requested.

The Delegate 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

The Notice of Action Taken letter 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"). The Delegate must maintain a log of all requests for criteria (see Attachment 14-1b in Section 14, "Attachments").

4. **Annual Assessment of Consistency of UM Decisions (Inter-rater Reliability):** IEHP provides oversight of delegated UM activities by monitoring, reviewing, and measuring the denial and referral process on an on-going basis and by performing audits. Delegates are responsible for evaluating, at least annually, the consistency with which all appropriate practitioners included in utilization review apply appropriate criteria for decision-making.

5. **Behavioral Health Triage and Referral:**

   a. For Healthy Kids – Riverside County, behavioral health services are a 'carve out' to the county's mental health department. Members can self refer, to behavioral health practitioners for treatment in their respective counties. IEHP Member Services can assist Members desiring to self-refer and /or with accessing behavioral health services as needed.

   b. For (both counties) Healthy Families and Healthy Kids – San Bernardino County, 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.

      1) 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.

      2) 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.

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

C. **Delegate UM Structure:**

1. Delegated entities must have the following UM structure and processes in place:

   a. UM Program Description, policies, procedures, and UM activities that meet IEHP and NCQA standards. These policies and procedures must ensure that decisions based on the medical necessity of proposed health care services are consistent with sound clinical principles and processes. These policies and procedures must address the Delegate's responsibility for continuity and coordination of care for Members with medical and/or behavioral health needs. The UM Program must be evaluated, and updated if necessary, at least annually.

   b. Authorization processes for specialty referral, specified diagnostic or therapeutic services, home health, elective surgeries, etc.

   c. Coordination of care and discharge planning with IEHP UM for inpatient Members, as applicable.

   d. Management of out-of-network emergency for Members.

   e. Availability of UM staff, at least 8 hours a day during normal business days, to respond to providers and practitioners regarding UM issues.

2. **Delegate 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 all approved or denied referrals to assure consistent processes 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.

3. **Delegate UM Committee** - Committee membership must include a minimum of three practicing physicians from the Delegate, 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.

4. **Delegate 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 IEHP's mandated 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 standards;

   i. Denial process that includes letters to Members, practitioners and monthly log report to health plans;

   j. Procedures for informing practitioners of referral process; and

   k. Dissemination of summary UM data to practitioners

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

   a. Providing sufficient information for decision making; and

   b. Following Delegate 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 and auto authorizations as indicated per the Delegate's policies.

b. RN/LVN – initial review of medical information, initial determination of benefit coverage, obtaining additional medical information, as needed, from practitioner 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 must review all the Delegate 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, the Delegate must demonstrate that there is a mechanism in place to ensure that all decisions are based on sound clinical judgment.

f. Delegates that utilize referral decision-making and hospital length of stay information for use with economic profiling must provide documentation to their PCPs and IEHP, if requested.

2. **Use of Board Certified Physicians for UM Decisions:** IEHP and contracted Delegates use 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 the case under review, a Board Certified physician in the appropriate specialty may be consulted.

   a. All contracted Delegates are required to have a written policy and procedure in place that addresses the process for the use of Board Certified Specialists for UM decisions.

   b. As part of the written process, contracted Delegates are required to 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.

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

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

E. **Authorization, Inpatient Review, and Notification Standards:** Mandated timeframes for decisions including approval, denial or modification of a request and subsequent notification to the Member and practitioner are outlined below. See Policy 11B, “Prior Authorization for Non-Formulary Medications,” for further details regarding pharmaceutical pre-authorization guidelines:

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

   a. Delegate 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 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 Prior authorization for all

outpatient services and elective admissions should take place at an IEHP network facility.

When the service required appears to be unavailable within the IEHP Network, the Delegate must not approve the service/admission until contacting IEHP's UM Support Services Manager, at (909) 890-2909 for immediate assistance.

If IEHP determines the requested service cannot be provided within the network, IEHP will initiate the Letter of Agreement (LOA) process. This process may take 1-2 days to complete. It is critical that the Delegate fax the referral with all supporting documentation as soon as possible to (909) 890-5538 to prevent a possible delay of care.

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

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 telephone number and fax number to the referring physician for any questions or communication regarding the referral.

b) The **Delegate's** decision to approve, modify, deny or terminate must be made within **five working days** from receipt of the request. If additional information is necessary in order to make a determination, the Delegate should contact the requesting practitioner for the additional clinical information within 24-hours, preferably by phone. The Delegate must annotate that additional information has been requested, include the date of the request and conclude the decision process within 5 working days of receiving 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 of all decisions by the Delegate, in writing, within two working days of the determination.

b. **Prior Authorization for Urgent/Emergent Pre-Service Decisions:**

1) Prior authorization is not required for emergent services. Emergent services are defined by the prudent layperson, such as:

a) A medical condition exists which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in:

i. 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

ii. Serious impairment to bodily function; or

iii. Serious dysfunction of any bodily organ or part.

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

3) Practitioners must submit urgent referrals the same day of the determination that the referral is necessary. Decisions to approve, modify, or deny authorization for urgent services must be completed within **72 hours** (includes weekends and holidays) of receipt of the request.

a) The Delegate has 48 hours after receipt of an urgent request to determine if it is non-urgent.

b) The Delegate RN/LVN reviewer or physician reviewer must communicate the change to non-urgent status by telephone or fax.

c) Telephonic communication must be documented, including date, time and name of contact person at the practitioner's officer, and name of the RN/LVN, or physician reviewer.

d) Fax communication to the practitioner should state that the request did not meet the following definition of urgent pre-service:

i. 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

ii. 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.

4) Practitioners must be initially notified within 24 hours of the decision by telephone or fax. The Member may be initially notified of the denial decision within 72 hours of the receipt of the request. Telephonic communications of decisions must be documented including date, time, name of contact person, and initials of person making the call.

5) Both the Member and practitioner must be notified of all decisions by the Delegate, in writing, within 72 hours from receipt of the request. If the Member receives oral notification within 72 hours of the receipt of the request, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.

6) The Delegate must notify both the practitioner and Member utilizing the IEHP approved "Notice of Action" template (see Attachment 14-2 in Section 14, "Attachments") and provide "Your Rights" attachment (see Attachment 14-11 in Section 14, "Attachments") with all denial letters that instructs a Member or Member representative on the appeal/grievance process.

c. **Post-Service Decisions (Retrospective Review):**

1) Services rendered without prior authorization require retrospective review for medical necessity and/or benefit coverage. This can include out-of-area admissions and/or services or treatments rendered by a contracted or non-contracted practitioner/Provider without prior authorization.

2) Relevant clinical information must be obtained and reviewed for medical necessity based on approved clinical criteria. If medical necessity is not met, denial determinations must be made by the Delegate Medical Director.

3) Retrospective review decisions and written notification to the Member and practitioners **must be made within 30 calendar days** from receipt of the request.

4) 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, and payment must be made for the medical screening exam (MSE)]

d. **Experimental and Investigational Determinations:**

1) The determination for all experimental and investigational services is the responsibility of IEHP. All authorization requests for experimental/investigational services must be sent as soon as possible after receipt by facsimile to IEHP, attention Medical Director at fax number (909) 890-5538, using the Health Plan Referral Form for Out-of-Network and Special Services (see Attachment 14-12 in Section 14, "Attachments"). . The request must include all supporting clinical information including diagnosis (ICD-9) and procedure (CPT) codes. IEHP is responsible for decision-making and notifying the provider, member and Delegate of the determination, per standard timeframes for level of urgency.

2) If there is an IEHP UM Subcommittee Clinical Authorized Guideline (CAG) regarding the requested experimental/investigational service, the Delegate can cite the guideline and issue the Notice of Action (NOA) letter.

e. **Denial Notices**: Any denial, in whole or in part, of a requested health care service must be reviewed and approved by the Delegate UM Medical Director, physician designee, or UM Committee. Members must receive an approved IEHP Notice of Action (NOA) letter including all your rights required attachments for any requested referral that is denied, modified, or terminated as appropriate. The Delegate is responsible for notifying Members of the reason for denial and citing the criteria or benefit coverage information used to render the decision. Any denial notices regarding experimental investigational therapy are the responsibility of IEHP, as stated above.

f. **Denial letters must include the following** (see Attachments 14-2 in Section 14, "Attachments"):

1) Required Department of Managed Health Care (DMHC) language (in bold within sample);

2) Required Department of Health Care Services (DHCS) language;

3) The right to appeal this decision; file a grievance, ask for an Independent Medical Review (IMR), refer to attachment "Your Rights";
4) 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 explanation of coverage (EOC) that excludes that coverage, i.e. the IEHP Member Handbook or State or Federal regulation, including the page number and/or give the State or Federal Regulation section; and
   c) Information on how the Member and practitioner can obtain the utilization criteria or benefits provision used in the decision.
5) Information for the Member regarding alternative direction for follow-up care or treatment.

g. 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. Such communication must 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 that they can appeal the decision to the Delegate Medical Director, IEHP Chief Medical Officer or the IEHP Medical Director. If the practitioner chooses to appeal the denial or modification to the Delegate, and the Delegate upholds the original decision, the subsequent letter must inform the practitioner of their right to submit a formal appeal to the IEHP Grievance and Appeals Department. If the Delegate upholds the denial or modification decision of an urgent referral, the Delegate must send all information to IEHP's Medical Director for review, no later than one business day following the decision to uphold the denial or modification.

h. On a monthly basis, the Delegate must send documentation of each denial, including denial logs and letters, to IEHP for monitoring purposes as outlined in Policy 14B, "Utilization Management Reporting Requirements."

i. IEHP and contracted Delegates shall retain information on all 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 screening exam (COBRA exam) performed at an Emergency Department or for 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 possesses 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 Healthy Families and Healthy Kids Members, emergency service and care also means an additional screening examination and evaluation by a physician or appropriate health care professional to determine if a psychiatric emergency medical condition exists.

c. For further details see Policy 14F, “Emergency Services.” All emergency care costs are covered when authorized by IEHP, or its designee, or a Delegate representative.

4. **Standing Referrals:** Delegates are required to have 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. Delegates must have a system in place to track such referrals/Members and must authorize care for a 3-6 month period.

5. **Behavioral Health:** IEHP is responsible for oversight of the UM processes associated with behavioral health and substance abuse services for Healthy Families and Healthy Kids – San Bernardino Members. This includes the retrospective review of UM data for continuous quality improvement in UM processes.

6. **Vision Services:** For Healthy Families Members, medical or surgical treatment of the eyes may be a covered benefit under IEHP when medically necessary. Routine vision exams, screening, eye glasses, contact lenses, and vision aids are excluded from the benefit. For Healthy Kids Members, IEHP is responsible for UM associated with vision services.

7. **Pharmacy Services:** IEHP does not delegate the responsibility for UM decisions associated with pharmacy services. Please refer to Section 11, "Pharmacy," for further details.

F. **Delegated UM Requirements** – Delegates must meet the following requirements for UM processes:

1. **Services Requiring Prior Authorization:** Each Delegate must maintain a list of services that require prior authorization or have a list of services that do not require prior authorization.

2. **Medical Necessity Determination:** Delegates must determine medical necessity for a specific requested service 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 IEHP UM Subcommittee Approved Authorized 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 use of an outside service.

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.

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. **Denial due to lack of documentation:** The Delegate must include in the denial letter to the Member and Provider the specific clinical criteria necessary to meet the requirements (e.g. diagnosis, labs, premiums, treatments, etc).

6. **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 Delegate UM Medical Director and/or UM Committee. Specialists caring for Members can request referrals directly from the Delegate.

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

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:** Delegate 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. **Delegate Documentation:** Delegates must have a procedure in place to log requests by date and receipt of information so that timeframes and compliance with those timeframes can be tracked. Delegate documentation of authorizations or referrals must include, at a minimum: Member name and identifiers, description of service or referral required, medical necessity to justify service or referral, place for service to be performed or name of referred physician, and proposed date of service. 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 Delegate 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 Delegate 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 coordination of care with IEHP and facilities the following activities related to discharge planning:

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

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

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

8. **Review of UM Data:** Delegates must collect, report and analyze UM data related to Members (see Attachment 14-3a in Section 14, “Attachments”).

   a. UM data reported 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; and

      6) Emergency encounters.

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

   c. Presentation of selected data from above to Delegate 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 Delegate UM Committees for trends by physicians for both over-utilization and under-utilization.

H. **Grievance Process:** IEHP maintains a formal Grievance Resolution System to ensure a timely and responsive process for addressing and resolving all Member grievances and appeals. IEHP acknowledges and resolves UM related grievances and appeals in accordance with state and federal regulatory guidelines. The Member may file a grievance by phone, by mail, fax, website, or in person. Please refer to Section 16, "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 Member's assigned Delegate's 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, the Delegate must make arrangements for the Member to see a physician in the appropriate specialty. If the referral is denied, the Delegate must provide written notification to the Member including rationale for the denial. Members disagreeing with a denial of a second opinion may register a grievance through the IEHP grievance process. Refer to Policy 14E, "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 as the FDA. 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 or 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. **Delegated UM Responsibilities:** IEHP delegates all aspects of UM activities related to medical services for assigned Members to contracted Delegates. All medical services are arranged for or provided by professional personnel and at physical facilities according to professionally recognized standards of medical practice and healthcare management. Delegate medical services must be rendered by qualified medical practitioners, unhindered by fiscal and administrative management. All contracted Delegates must further agree to provide or arrange for referrals to specialists and facilities as are necessary, appropriate, and in accordance with generally accepted managed care industry standards of medical practice, in compliance with the standards developed by IEHP and NCQA.

M. **Non-delegated 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 Medi-Cal Managed Care 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. The authorization system is also in place for vision services for Healthy Kids Members and behavioral health referrals for the Healthy Families Members and Healthy Kids – San Bernardino Members.

N. **Monitoring Activities and Oversight:** IEHP monitors and oversees delegated UM activities performed by Delegates. The following oversight activities are performed to ensure compliance with IEHP UM 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. **Annual Delegation Oversight Audit** – IEHP performs a Delegation Oversight Audit of all Delegates on an annual basis to review the Delegate’s UM policies, procedures, and activities. This audit re-assesses the Delegate’s operational capabilities in the areas of QM, Medical Records, Preventive Health, Members Rights and Responsibilities, Credentialing, UM, and Care Management. The IEHP Medical Director reviews all audit findings and addresses any issues to the UM Subcommittee.

3. **Analysis of Provider Data Reports** – The Delegate UM Liaison and Director of Utilization reviews required IEHP and Delegate reports and utilization data including UM trend reports, second opinion tracking logs, denial logs, and letters, and semi-annual and annual work plans.

4. **Review of Denial Logs and Letters** – All Delegates are required to submit monthly denial logs (see Attachment 14-4 in Section 14, “Attachments”), and denial letters to IEHP listing the denied referrals, clinical information, and denials

and modifications of referrals from the previous month. Delegates are required to submit copies of all denial letters sent to Members and to practitioners. If the practitioner appeals a denial to the Delegate, and the Delegate upholds the decision, the notification letter sent to the practitioner, regarding the upheld decision, must be submitted to IEHP with the monthly submission of denials. All denials are reviewed for appropriateness by the Delegate UM Liaison and Director of Utilization Management or designee.

5. **Focused Referral and Denial Audits:** IEHP performs focused audits of the referral and denial process for Delegates. Please refer to Policy 14D, "Focused Referral and Denial Audits." Audits examine source data at the Delegate to determine referral process timelines and appropriateness of denials and the denial process, including denial letters (see Attachments 14-7 and 14-8 in Section 14, "Attachments").

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

7. **Delegation Oversight Audits (MMA)**: IEHP performs monthly denial letter audits and the annual onsite Delegation Oversight audits of all Delegates to review the UM process, that includes approved referral audit and non-emergent file review. Please refer to Policy 13E, "Delegate Oversight – Delegate Delegation Oversight Audit," for further details.

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

O. **Enforcement/Compliance:** IEHP monitors and oversees delegated UM activities performed by Delegates. Enforcing compliance with IEHP standards is a critical component of monitoring and oversight of IEHP Providers, particularly related to delegated activities.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Effective date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revised date:**	January 1, 2012

14. UTILIZATION MANAGEMENT

B. Utilization Management Reporting Requirements

APPLIES TO:

A. This policy applies to all Healthy Families and Healthy Kids Members.

POLICY:

A. All IPAs must report Utilization Management (UM) information to IEHP as described below on a monthly, semi-annual and annual basis.

B. IPA reports must be received by IEHP electronically using a File Transfer Protocol (FTP) server.

C. Reports are due on or before the due dates regardless if the due date is a weekend or a holiday.

PROCEDURE:

A. **Monthly Reporting Requirements:**

1. Reporting requirements include a monthly assessment of utilization data and denial activity. Monthly reports are due to IEHP by the 15th of the month following the month in which services were rendered or denials made, and include the following:

   a. **Utilization Data** - Include all data listed on the "Monthly Utilization Trend Report Instructions" (see Attachments 14-3a in Section 14, "Attachments"). There must be a separate report for Healthy Families and Healthy Kids lines of business (see Attachments 14-3b and 14-3c in Section 14, "Attachments").

   b. **Denials and Modifications** - Include all referral and clinical information and copies of all denial letters included on the "Monthly Denial Listing" (see Attachment 14-4 in Section 14, "Attachments"). Modifications occur when a decision is made and proposed care is denied or altered.

   c. **Second Opinion Tracking Log –** Include all authorizations, modifications, and denial information for second opinion requests. The Log must include the reason the second opinion was requested (see Attachment 14-9 in Section 14, "Attachments").

B. **Semi-Annual Reporting Requirements:**

1. UM Semi-Annual Reports must be submitted to IEHP by the 15th of the month followings months, February and August. The reports should include, at a minimum, UM goals and activities, trending of utilization activities for under and over utilization, Member and practitioner satisfaction activities, and interrater

reliability activities and improvement. The Semi-Annual report due in February must also include the UM Program Annual Evaluation that is the IPAs evaluation of the overall effectiveness of the UM Program, including whether or not goals were met.

C. **Annual Reporting Requirements:** The following reports must be submitted annually to IEHP by the last day of February of each calendar year:

1. **UM Program Description:** Reassessment of the UM Program Description must be done on an annual basis by the UM Committee and/or QM Committee and reported to IEHP including the following:

   a. Any changes made to the UM Program Description during the past year or intended changes identified during the annual evaluation; and

   b. UM Program Description Signature Page.

2. **UM Work Plan:** Submit an outline of planned activities for the coming year, including timelines, responsible person(s) and committee(s). The Work Plan should include measurable goals, planned audits, follow-up activities and interventions related to identified problem areas.

D. All reports must be submitted to IEHP within the timeframes specified via IEHP's File Transfer Protocol (FTP server).

E. Persistent failure to submit required reports may result in action that includes, but is not limited to, request for Corrective Action Plan (CAP), freezing of new Member enrollment, termination or non-renewal of the IEHP Agreement.

F. Any discrepancies in reported information are addressed with the IPA in accordance with monitoring activities outlined in Policy 14A, "Utilization Management Delegation and Monitoring."

INLAND EMPIRE HEALTH PLAN		
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Chief Title: Chief Medical Officer	**Revised date:**	January 1, 2012

14. UTILIZATION MANAGEMENT

C. Review Procedures

1. Primary Care Physician (PCP) Referrals

APPLIES TO:

A. This policy applies to all IEHP Healthy Families and Healthy Kids 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 their IPA referral process.

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

PROCEDURE:

A. Referrals to specialists, second surgical opinions, hospital admissions, or any service which require prior authorization for procedures are initiated by PCPs or specialists through the IPA for delegated services. Prior authorization of proposed services, referrals, or hospitalizations involve the following:

   1. Verification of Member eligibility by the IPA;

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

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

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

B. PCPs must maintain a Referral Tracking Log for all referrals submitted to IPAs for approval, in accordance with Policy 14C1a, "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. Decisions for routine referrals must be made within five working days of receipt of request. Decisions must be made within 72 hours for urgent referrals. The PCP informs Members that if the referral is denied or modified, they can file an appeal/grievance with IEHP. A written notice of denial that includes the appeal/grievance process must be provided.

D. Referrals to specialists or out-of-network practitioners require documentation of medical

necessity, rationale for the requested referral and prior authorization from the IPA. Once the prior authorization has been obtained, the PCP must continue to monitor the Member's progress to ensure appropriate intervention and assess the anticipated return of the Member to the IEHP network.

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

   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, with oversight by IEHP.

F. Denial logs and letters for in-network and out-of-network denials and modifications must be maintained by the IPA. Denial logs and letters must be sent to IEHP on a monthly basis for monitoring purposes. Information on the denial logs must include at a minimum: Member name, IEHP number, requesting physician name, date of referral or request, the specifics of referral or request, diagnosis, decision by IPA (approval, denial, or modification specifics) alternatives offered, and date of decision.

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

H. Referrals for behavioral health services for all IEHP Healthy Families and Healthy Kids Members are initiated by the PCP or IPA through IEHP. See Policies 12G1a and 12G1b, "Behavioral Health Services," and 12G2a and 12G2b, "Alcohol and Drug Treatment Services" for Healthy Families and Healthy Kids Members.

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14. UTILIZATION REVIEW

C. Review Procedures

1. Primary Care Physician (PCP) Referrals

a. PCP Referral Tracking Log

APPLIES TO:

A. This policy applies to all IEHP Healthy Families and Healthy Kids Members.

POLICY:

A. All PCPs must maintain a system for tracking all referrals submitted to their IPAs for Members.

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 (Urgent or Routine);
5. Reason for Referral or Diagnosis;
6. Service/Activity Requested;
7. Date referral returned;

B. Referral Decision (Approved, Modified, Denied);

1. Date Patient Notified;
2. Date of Appointment or Service; and
3. Date Consultation or other Report Received

C. PCPs may either use the PCP Referral Tracking Log (see Attachment 14-5 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 and to obtain assistance from their IPA if specialty appointments are delayed, or consultation notes are not received.

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

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

14. UTILIZATION REVIEW

C. Review Procedures
1. Primary Care Physician (PCP) Referrals
a. PCP Referral Tracking Log

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Chief Title: Chief Medical Officer	**Revised date:**	January 1, 2009

14. UTILIZATION MANAGEMENT

C. Review Procedures

2. Standing Referral/ Extended Access to Specialty Care

APPLIES TO:

A. This policy applies to all IEHP Healthy Families and Healthy Kids Members.

POLICY:

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

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

C. Practitioners that are Board 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 (800) 440-4347.

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

PROCEDURE:

A. IPAs must develop and implement a procedure 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 specialty referral or extended access to the IPA in writing, using the designated form (see Attachment 14-6 in Section 14, "Attachments"). Appropriate medical records must be attached to the request.

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

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

E. Treatment plans must be submitted to IEHP Care Management by fax at (909) 890-2198. IEHP must make its determination regarding the treatment plan within three business days.

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

G. 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.

H. 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.

I. 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 a 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

a HIV/AIDS specialist. An HIV/AIDS specialist is a physician who holds a valid, unrevoked 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 IPA is not required to refer the Member to a non-network provider unless 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 IPA Medical Director and/or PCP in consultation with IEHP's Chief Medical Officer, when warranted.

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

K. After approval of the standing specialty or extended access to specialty care with or without a treatment plan, IPAs are required to notify the PCP, specialist and Member in writing of the specifics of the determination, within two business days of the determination.

L. All denials of standing specialty referral requests or extended access to specialty care must be forwarded to IEHP within three business days of the denial. IPAs must also inform the PCP, specialist and Member of the denial in writing, according to prescribed formats for denials. Please refer to Policy 14A, "Utilization Management Delegation and Monitoring."

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

Out of Network

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

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

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

D. IPAs are not required to refer Members to an out-of-network HIV/AIDS specialist unless an appropriate HIV/AIDS specialist, or qualified nurse practitioner or physician assistant under the supervision of an HIV/AIDS specialist is not available within the network, as determined by the IPA in conjunction with IEHP's Chief Medical Officer, as warranted.

INLAND EMPIRE HEALTH PLAN		
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Chief Title: Chief Medical Officer	**Revised date:**	January 1, 2012

APPLIES TO:

A. This policy applies to all IEHP Healthy Families and Healthy Kids Members.

POLICY:

A. Per IEHP Policy 14A, "Utilization Management Delegation and Monitoring," Utilization Management (UM) activities are delegated to contracted Delegates that meet IEHP UM standards.

B. IEHP provides oversight of delegated IPAs by monitoring, reviewing, and measuring the denial and approved referral process on an ongoing basis as outlined under Policy 14A, Utilization Management Delegation and Monitoring."

C. Audits examine source data at the IPA for review of referral process timeliness, appropriateness of denials and the denial process, including denial letters.

D. IEHP performs a Delegation Oversight Audit of all Delegates on an annual basis to review the UM process, that includes an approved referral audit. Focused approved referral and denial audits are also performed when issues are identified.

PROCEDURE:

Monthly Retrospective Denial Audit

A. IEHP performs a monthly retrospective audit of denied and modified referrals submitted monthly by the IPA.

B. IEHP uses the Non-Emergent File Review Tool for the monthly retrospective denial audits to evaluate referral timeliness and document the examined referral results (see Attachment 14-8 in Section 14, "Attachments").

C. In order to pass the monthly audit, the Delegates must achieve:

1. A score of 80% or greater on the overall score; and
2. A score of 80% or greater for compliance with time and turnaround; and
3. A score of 80% or greater for using the correct template and attachments for the Members LOB.

D. When the IPA fails to achieve a passing score for two (2) consecutive months, one or more of the following sanctions will occur:

1. A request for a Corrective Action Plan (CAP) may be issued; or
2. 100% concurrent denial review may be initiated during which time the IPA will receive a score of zero for each month the concurrent review is conducted; or

3. The IPA may be frozen to new Member enrollment until the IPA passes the monthly audit for two (2) consecutive months.

E. Persistent non-compliance may result in the termination of the IPA contract.

Annual Delegation Oversight Audit

A. IEHP performs an annual onsite Delegation Oversight Audit of all IPAs to review the UM process, that includes approved referral audit and non-emergent file review.

B. IEHP staff notifies the IPA in writing two weeks in advance of the scheduled annual audit. IEHP reserves the right to give as little as 24 hours verbal notice for focused audit that occur between annual audits.

C. Audit staff from IEHP includes at a minimum, the IPA UM Liaison. In addition, the IEHP Medical Director, Director of UM, or other staff may participate.

D. UM Process Review Components:

1. Approved Referral File Review

    a. The IPA is notified by a letter issued prior to the Delegation Oversight regarding the randomly selected file dates that will be used for the approved referral audit.

    b. The IPA must submit a log to IEHP within one week of the date of the notification letter identifying the approved referrals processed on the selected dates.

    c. IEHP subsequently notifies the IPA one week prior to the scheduled Delegation Oversight of the forty (40) approved referrals selected from the log. These files must be available for the reviewer(s) at the Delegation Oversight.

2. Non-Emergent File Review

    a. The final score of the Non-Emergent File Review section of the Annual IPA Delegation Oversight is derived from the total points earned each month on the monthly retrospective denial audit for the period of July 1st of the previous calendar year through June 30th of the current year.

    b. In order to pass this section of the audit, the IPA must achieve a minimum passing score of 80%.

E. As part of the audit, IEHP requests details of the process used by the IPA to follow-up and assure that Members receive approved services.

F. IEHP audit staff conducts a verbal exit conference with IPA staff at the end of an audit.

G. Within thirty (30) days of the audit, a final score and cover letter are sent to the IPA.

H. IPAs pass the audit if the following scores are achieved:

   1. 80% of approved and denied referrals are processed within IEHP timeliness standards.
   2. 80% of denials and denial letters meet criteria for accuracy and appropriateness of the denial; and
   3. 80% of the denials/modifications must be issued on the correct Notice of Action (NOA) Template for Member's Line of Business (LOB).

I. IPAs that pass the Approved Referral Audit Section of the annual IPA Delegation Oversight will not be subject to a routine audit for at least one year. Focused Approved Referral Audits may still occur under the circumstances outlined in the "Focused Audits" section below.

J. IPAs that score below 80% on the approved referral audit are required to submit a Corrective Action Plan (CAP) addressing all deficiencies noted at the audit within a specified timeframe. All IPAs scoring below 80% are re-audited within sixty (60) days. IPAs that continue to score below 80% are required to submit CAPs and are re-audited at least every sixty (60) days until a passing score is achieved.

K. Re-audits are performed by the IPA UM Liaison and potentially the IEHP Medical Director and/or Director of UM. IPAs are given a minimum of five working days notice for re-audits. IEHP examines a minimum of ten (10) approved referrals.

L. IPAs that fail re-audits may be subject to the following actions:

   1. Continued requirements for CAPs and re-audits;
   2. Freezing the IPA to new Member enrollment; or
   3. Termination of the IEHP-IPA contract; or non-renewal of the IPA contract.

M. IPAs who disagree with audit results can appeal through the IEHP Provider appeals process by submitting an appeal in writing to the IEHP Chief Medical Officer.

N. Audit results are included in the overall annual assessment of IPAs.

Focused Audits

A. Focused audits are conducted under the following circumstances:

   1. Review of grievances by IEHP demonstrates more than twice the IEHP per 1000 Member rate and six practitioner grievances related to the referral process for a given IPA in a three year period. Grievance rates are captured on an ongoing basis per review of each case.
   2. Any Level 3 grievance related to the referral process for an IPA in a three-month period.

3. Follow-up audit for deficiencies noted on the annual IPA Delegation Oversight.
4. Review of denials demonstrate that decisions being made are inconsistent, do not appear to be medically appropriate, or are not based on professionally recognized standards of care.
5. Any other circumstance that in the judgment of the IEHP Chief Medical Officer requires a focused audit.

B. At the time of the focused audit, IPAs are instructed to produce thirty (30) approved referrals along with their letter or other documentation that the services were provided to and/or the Member was notified. If an IPA has fewer than thirty (30) approved referrals, all of those referrals must be produced.

C. IEHP selects twenty (20) of the thirty (30) approved referrals for review. If fewer than twenty (20) approved referrals are available, all referrals are reviewed.

D. If, during the focused audit, any of the selected referrals are deemed invalid by the reviewer (e.g., missing information or type of referral), the IPA must substitute an alternate referral acceptable to IEHP.

E. IEHP uses the Approved Referral Tool for Focused Approved Referral Audits to document the examined referral results and evaluate referral timeliness (see Attachment 14-7 in Section 14, "Attachments").

F. When the IPA fails to achieve a passing score on the focused audit, one or more of the following sanctions will occur:

1. A request for a Corrective Action Plan (CAP) may be issued;
2. 100% concurrent denial review may be initiated during which time the IPA will receive a score of zero for each month the concurrent review is conducted; and
3. The IPA may be frozen to new Member enrollment until the IPA passes the monthly audit for two (2) consecutive months.

G. Persistent non-compliance may result in the termination of the IPA contract.

INLAND EMPIRE HEALTH PLAN		
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Chief Title: Chief Medical Officer	**Revised date:**	January 1, 2012

14. UTILIZATION MANAGEMENT

E. Second Opinions

APPLIES TO:

A. This policy applies to all IEHP Healthy Families and Healthy Kids Members.

POLICY:

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

B. Second opinions are authorized and arranged through the Member's assigned IPA.

C. 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 assigned IPA's prior authorization system. Members should request a second opinion through their PCP or specialist. If the PCP or specialist refuses to submit a request for a second opinion, the Member can submit a grievance or a request for assistance through IEHP Member Services at (800) 440-4347. IEHP's Member Services staff directs the Member to an IEHP Care Manager. The Care Manager assists the Member in contacting his/her IPA to request a second opinion.

B. The PCP or specialist submits the request for a second opinion to the IPA including documentation regarding the Member's condition and proposed treatment.

C. If the referral for a second opinion is approved, the IPA makes arrangements 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, the IPA provides written notification to the Member including rationale for the denial or modification, alternative care recommendations, and information on how to appeal this decision. Refer to Policy 14A, "Utilization Management Delegation and Monitoring."

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

were furnished within the network.

E. IPAs must provide and coordinate any out-of-network services adequately and timely.

F. Members disagreeing with an IPA 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 and IPA. If determined by IEHP Medical Services to be not urgent, the Member is referred back to his/her PCP and IPA to continue the process.

I. The IPA must utilize a Second Opinion Tracking Log (see Attachment 14-9 in Section 14, "Attachments") 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 and must be submitted on a monthly basis, by the 15th of the following month, to IEHP's Quality Management (QM) department.

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 within the same IPA.

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, from any IPA within the IEHP network. If the specialist is not within the same IPA, IEHP incurs the cost of that second opinion. If not authorized, additional medical opinions obtained by a physician not within the assigned IPA are the responsibility of the Member.

M. The IPA is responsible for submitting a copy of all authorizations, modifications, and denials of second opinions to the PCP.

N. 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.

O. 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.

P. The PCP is responsible for documenting second opinions and monitoring receipt of consultation reports on the PCP Referral Tracking Log (see Attachment 14-5 in Section 14, "Attachments").

Q. Mandated timeframes for decision including approval, denial or modification of a non-urgent or urgent or concurrent request for a second opinion and subsequent notification to the Member and practitioner must follow the timeframes outlined in Policy 14A, "Utilization Management Delegation and Monitoring."

R. If the referral is denied or modified, the IPA provides written notification to the Member including rationale for the denial or modification, alternative care recommendations, and information on how to appeal this decision.

   1. Member, Member's Representatives, or practitioners appealing on behalf of the Member, disagreeing with a denial of a second opinion may appeal through the IEHP grievance process.

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

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Effective date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revised date:**	January 1, 2012

14. UTILIZATION MANAGEMENT

F. Emergency Services

APPLIES TO:

A. This policy applies to all IEHP Healthy Families and Healthy Kids Members.

POLICY:

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

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

C. Per regulatory requirements, IEHP 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.

      d. For Healthy Families and Healthy Kids Members, emergency service and care also means an additional screening examination and evaluation by a physician to determine if a psychiatric emergency medical condition exists, as applicable.

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

   1. IPAs are financially responsible for:

      a. All professional fees associated with the diagnosis and/or treatment of an ED visit when the Member has an emergency medical condition;

      b. All professional components of an ED visit authorized by a PCP, IPA, or IEHP designee regardless of whether the visit was emergent or non-emergent;

      c. The professional components of the MSE for non-authorized, non-emergent visits; and

      d. All facility components for authorized, non-emergent visits.

2. IEHP, is financially responsible for:
   a. All facility and technical fees when a Member has an emergency medical condition; and
   b. The facility and technical components of a MSE for non-authorized, non-emergent visits.

E. If it is determined that the Member's condition was not emergent, the IPA is responsible for the MSE, at a minimum. The IPA is not required to notify the Member 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 by the IPA.

F. Emergency services can be subject to retrospective review by the Hospital or IPA. IPAs 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.
   1. Hospitals can forward to the IPA any facility costs associated with a visit to an ED that was authorized by an IPA or PCP, and judged non-emergent after medical review by a hospital staff physician.
   2. If medical review of the claim by the IPA determines that the authorized visit was for a Member with a non-emergency medical condition, then the IPA is financially responsible for the facility and technical components of the visit.
   3. Where conflict regarding payment decisions cannot be resolved between Hospital and IPA, claims can be submitted to IEHP for final adjudication.

G. IPAs are encouraged to develop contractual arrangements with EDs.

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

<u>PROCEDURES:</u>

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 and are not limited to:

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, IPA, or designee for authorization of services or treatment beyond the MSE.

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

D. Authorized ED visits can be subject to review by IEHP, to determine if an emergency medical condition was present. If medical review determines that an emergency medical condition was not present, the facility and technical components of the claim will be reviewed for payment. The Hospital can appeal adverse payment decisions IEHP review.

E. Examples of non-emergent ED visits could include but are not limited to:

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.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Effective date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revised date:**	January 1, 2012

G. Pre-Service Referral Authorization Process

APPLIES TO:

A. This policy applies to all IEHP Healthy Families and Healthy Kids Members.

POLICY:

A. To ensure timely access to specialty care for IEHP Members, IEHP has adopted mandated for specialty referrals.

B. PCPs are responsible for providing general medical care for Members and requesting specialty care, diagnostic tests, and other medically necessary services either through the IPA or 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 and IPAs must have a process in place to allow a specialist to directly request authorization from IEHP or the IPA for additional specialty consultation, diagnostic or therapeutic services.

E. IEHP and IPAs 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 and IPAs are responsible for verification of Member eligibility and plan benefits.

D. IEHP and IPAs 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 14-10 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 14-10 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 and IPAs should monitor the PCP's rates of referrals to specialists to:

   1. Monitor for potential over or under utilization of specialists;

   2. Identify referral requests that are within the scope of practice of the PCP.

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

I. There must be documented evidence of the corrective action taken by IEHP or the IPA, 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

H. Wheelchair Purchase Referral Procedure

APPLIES TO:

A. This policy applies to all IEHP Healthy Families and Healthy Kids Members.

POLICY:

A. The IPA is responsible for authorizing all non-custom wheelchair purchases and wheelchair rentals.

B. 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.

C. Custom wheelchair requests should be reviewed by the IPA Medical Director. Requests that meet criteria are forwarded to IEHP for wheelchair purchase.

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

E. IEHP is responsible for repairs and maintenance of custom wheelchairs for qualifying individuals.

PROCEDURES:

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

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

C. The IPA needs to submit, via fax, the referral with all supporting documentation to IEHP's Utilization Management (UM) department no later than one business day from the IPA's decision.

   1. The referral form must be faxed to IEHP's UM department at 909-890-5528 for review and coordination of services with a Seating Evaluation as applicable.

   2. Referral requests to IEHP for the purchase of a custom wheelchair must be accompanied at a minimum with the following:

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

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

c. The medical necessity evaluation from the physiatrist or orthopedist.

D. IEHP's UM department will review the referral and the supporting documentation and make a determination within two business days from the receipt of the referral from the IPA.

E. Notification will be provided to the IPA, requesting provider, PCP, and seating evaluator regarding the determination.

F. IEHP's UM Department will send notification to the IPA for care management and/or care coordination services.

G. IEHP will arrange for the Member to be assessed at a Seating Clinic, either facility based or in the home, to determine equipment needs.

H. 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 Clinic as applicable.

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

J. IEHP is responsible for all repairs and maintenance of purchased custom wheelchairs. If an IPA receives a request for such services, the referral must be faxed to the IEHP UM department at 909-890-5528 within one business day of receipt of the request.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Effective date:**	August 1, 2007
Chief Title: Chief Medical Officer	**Revised date:**	January 1, 2011

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	Notice of Action Taken	14A
14-3	Monthly Utilization Trend Report	
	a. Instructions	14A, 14B
	b. Healthy Families Utilization Trend Report	14B
	c. Healthy Kids Utilization Trend Report	14B
14-4	Monthly Denial Listing	14A, 14B
14-5	PCP Referral Tracking Log	14C1a, 14E
14-6	Standing/Extended Access Referral to Specialist Request Form	14C2
14-7	Approved Referral Audit Tool	14A, 14D
14-8	Non-Emergent File Review Tool	14A, 14D
14-9	Second Opinion Tracking Log	14A, 14B, 14E
14-10	Specialty Office Service Auth Sets Grid	14G
14-11	Your Rights	14A
14-12	Health Plan Referral Form for Out-of-Network/Special Services	14A

<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
REQUEST FOR UM CRITERIA LOG

IPA Name: ________________________________ 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)	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

[Provider Organization Logo]

NOTICE OF ACTION
About Your Treatment Request
(*NOTIFICACIÓN DE ACCIÓN*
***Sobre su solicitud para Tratamiento*)**

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Member's DOB]:
[Member's I.D. Number]:
[Requesting Provider's Name]:
[Health Plan Name]:

RE: *[service requested]*
[Provider Organization Tracking Number*]*:

[insert name of requesting provider] has asked (*ha pedido a*)*[name of IPA*] to approve (*que apruebe*) *[insert type of treatment requested].* This request is (*Esta solicitud fue*) [Insert Denied (*Negada*), Modified (*Modificada*) or Terminated (*Terminada*)] because (*porque*):

*[FOR **MEDICAL NECESSITY** DENIALS INSERT THE FOLLOWING TEXT]*
The service or item requested was reviewed by our doctor and it has been determined that the requested item or service is not medically necessary. This decision has been made because: (*El servicio o articulo solicitado fue revisado por nuestro doctor y a sido determinado que no es médicamente necesario. Esta decisión fue tomada porque:*) [Insert a clear and concise explanation of the reasons for the decision or alternatives provided, or reason for terminating service. The detail must contain a citation/description of the criteria or guidelines used, including the plan authorization procedures supporting the action and the clinical reasons for the decision regarding medical necessity].

[*FOR **BENEFIT COVERAGE** DENIALS INSERT THE FOLLOWING TEXT (For Exclusions Only*)]
The requested service or item is not covered under your benefits with IEHP. This decision has been made because: (*El servicio o articulo solicitado no es cubierto bajo sus beneficios con IEHP. Esta decisión fue tomada porque*:*)*
[Insert section, i.e. exclusions and limitations section] and [Insert a citation of the specific regulations supporting the action, i.e. Title 22, section #XXXXX, or section of the IEHP Member Handbook/Evidence of Coverage (EOC)].

Please refer to your "Member Handbook"/EOC for additional benefit coverage information. (*Por favor consulte a su "Manual de Miembros"/EOC para información adicional sobre beneficios cubiertos.*)

[*FOR **CALIFORNIA CHILDREN SERVICES** (CCS), INSERT THE FOLLOWING TEXT]:*
The requested service is a benefit under IEHP. However, because the Member has an open active case with the California Children Services (CCS) Program, CCS covers this request. To access this service, please contact your doctor or call your local CCS office at 800-*[insert #]*. Dr. *[insert name*]'s office has been given the telephone number to contact CCS for authorization. Please follow-up with your doctor's office. (*El servicio solicitado es un beneficio bajo IEHP. Sin embargo, porque el Miembro tiene un caso*

abierto y activo con el Programa California Children Services (CCS), esta petición es cubierta por CCS. Para obtener acceso a este servicio, por favor llame a su doctor o llame a su oficina local de CCS al 800-[insert #]. A la oficina del Dr. [insert name] se le ha dado el numero de teléfono para contactar a CCS para una autorización. Por favor acuda a la oficina de su doctor.)

If you need the above explanation translated, please contact: (*Si necesita la explicación anterior traducida, favor de llamar a:)*

[IPA Name]
[IPA Address]
[IPA Phone Number]

You may appeal this decision. The enclosed 'Your Rights' information notice tells you how. It also tells you where to go to get help, including free legal help. (*Usted puede apelar esta decisión. La información incluida "Sus Derechos" le dice como. También le dice como obtener ayuda, incluyendo ayuda legal gratuita.*)

This notice does not affect any other services you are receiving from IEHP. (*Esta notificación no afecta cualquiera otros servicios que usted recibe de IEHP.)*

Sincerely,

[IPA Representative]
Enclosed: "Your Rights" Under Managed Care *(Adjunto: "Sus Derechos" Bajo Administración de Cuidado a la Salud)*

cc: Requesting Provider
PCP
IEHP

Monthly Utilization Trend Report
Instructions

Enrollment – actual monthly membership assigned to IPA.

Re-admissions within 31 days of Discharge - actual number of IEHP Members re-admitted to inpatient facility within 31 days of prior discharge.

Total # of prior authorization requests - total number of prior authorization requests within the reporting period including specialty referrals, diagnostic services, therapeutic modalities, DME, etc. This includes approved, modified, and denied requests.

Total # of denials - total number of denied or modified prior authorization requests for the reporting period. Do not include requests deferred due to inadequate information.

Denial percentage - total number of denials and modifications divided by total number of prior authorization requests, multiplied by 100.

Actual # Emergency Department Visits – actual number of Emergency Room visits, excluding Urgent Care and/or Fast-Trac visits, for reporting month.

MONTHLY UTILIZATION TREND REPORT
HEALTHY FAMILIES

IPA Name: ______________________________ Date Submitted: ______________________________________

Report for Month of: ________________________________ Submitted by: ______________________________

Data Element	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Annualized
Enrollment													
Readmissions within 31 days of discharge													
Total # prior authorization requests (includes approved, modified & denied)													
***Total # denials (this number is denied referrals only)**													
Denial percentage (formula: denials / total # auths x 100)													
Actual # of Emergency Department Visits													

* Denials refer to those cases where a decision is made and proposed care is altered.

MONTHLY UTILIZATION TREND REPORT
HEALTHY KIDS

IPA Name: ______________________________ Date Submitted: ______________________________________

Report for Month of: ________________________________ Submitted by: ______________________________

Data Element	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Annualized
Enrollment													
Readmissions within 31 days of discharge													
Total # prior authorization requests (includes approved, modified & denied)													
***Total # denials (this number is denied referrals only)**													
Denial percentage (formula: denials / total # auths x 100)													
Actual # of Emergency Department Visits													

* Denials refer to those cases where a decision is made and proposed care is altered.

INLAND EMPIRE HEALTH PLAN
MONTHLY DENIAL LISTING

IPA Name: ______________________________ Date Submitted: ______________________________

Report for Month of: ______________________________ Submitted by: ______________________________

Member Name and IEHP ID #	Requesting Physician Name	Diagnosis	Procedure/Request	Request Date	Decision Date	Decision Code (circle one)	Reason/Alternative	*See Legend Below For Member Type
						Denied Modified		
						Denied Modified		
						Denied Modified		
						Denied Modified		
						Denied Modified		

* Legend: MC = Medi-Cal
HF = Healthy Families
HK = Healthy Kids

IEHP

INLAND EMPIRE HEALTH PLAN

Referral Tracking Log

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

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

Standing Referral / Extended Access Referral to Specialty Care Request

Health Plan____________________ Date of Request____________________________

IPA/MG______________________ PCP__________________________________

Phone #______________________ Phone #___________ FAX_____________

Requesting MD____________________________

Phone #___________ FAX_____________

Other Insurance________________ Phone #___________

Member Name_________________ DOB____/____/_____ M F Phone #__________

Address____

City____________________ State_____________ ZIP____________________

Member ID #____

Eligibility Reviewed Thru_________ Medi-Cal AEVS Confirmation #_______________

Policy/Group #_________________

Referral To (Physician Name):_________________ Type of Specialist:_______________

Phone #_________________ FAX_____________

Diagnosis Primary_____________________________________ ICD 9_____________

Diagnosis Secondary___________________________________ ICD 9_____________

Practitioner Treatment Plan (complete or attach)

# Visits/Period	Visits/3 Months	Visits/6 Months	Visits/9 Months	Visits/1 Year
Time Requested (fill in number of visits)				

Briefly, describe what is anticipated on each visit:

____

____

____

____

When was the diagnosis first made?____

How many times has the patient been seen by the specialist in the past year?__________________

Additional information regarding treatment plan may be requested from the specialist if necessary. If so, decision will be made within 3 business days of receipt of the information.

REVIEW COMMITTEE USE ONLY:

- Does diagnosis meet the criteria of long term, life threatening, degenerative, disabling disease or complex medical condition? Y ____________ N __________.
- Is specialist in the plan network? Y ____________ N __________.

If out of network, is contract between plan and specialist obtained? Y __________ N __________.
Date_____________.

Visits/Period of Time___________________.

Date Medical Information Received:________________________________.

Approved Date:________________. Modified Date:_____________. *Denied Date:____________.

Authorized by ________________________, M.D.
Medical Director or Designee

* If denied, indicate the reason for denial and alternatives suggested. Include this information in the denial letter.

Authorization #_______________. Date Valid From:__________. Thru:_____________________.

Decision made within 3 business days of receipt. Y ____________ N __________.

Notification Date: To Requesting Practitioner________________. By FAX____. Letter______.
To PCP________________________________. By FAX____. Letter______.
To Specialist Consultant__________________. By FAX____. Letter______.
To Member______________________________. By FAX____. Letter______.

Authorization remains valid only if Member is eligible.
Payment is contingent upon the patient’s eligibility at the time service is rendered.

IPA Delegation Oversight Audit Tool
Utilization Management
Approved Referral Audit Tool

IPA: ______________________ **Score:** ______________

Reviewed by: ______________________ **Review Date:** ______________

SCORING GRID: **Y** = Meets criteria; **N** = Does not meet criteria; Pass audit = 80%

		A	B	C	D	E	F	G	H
Member Name		**Date Referral Completed by PCP Office**	**Date Referral Received by IPA**	**Was Referral Urgent or Routine**	**Date of Decision**	**Number of Business Days Between B & D**	**Does # Days in D Meet Required Guidelines** (Y or N)	**Proof Service was Delivered or Member Notified**	**Member Notified Verbal or Letter** (V or L)
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									

Review a minimum of 10 records. If the first 10 meet criteria, then no further referrals necessary. If first 10 do not meet 100% then 25 charts are necessary.

INLAND EMPIRE HEALTH PLAN
IPA Delegation Oversight Audit Tool
Approved Referral Audit Tool

IPA Name: ___________________________

		A	B	C	D	E	F	G	H
	Member Name	**Date Referral Completed by PCP Office**	**Date Referral Received by IPA**	**Was Referral Urgent or Routine**	**Date of Decision**	**Number of Business Days Between B & D**	**Does # Days in D Meet Required Guidelines** (Y or N)	**Proof Service was Delivered or Member Notified**	**Member Notified Verbal or Letter** (V or L)
11.									
12.									
13.									
14.									
15.									
16.									
17.									
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IPA Name: ____

Description of process for facilitating approved services

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COMMENTS

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IE♥HP

IPA Delegation Oversight Audit Tool
Utilization Management
Non-Emergent File Review

IPA: ______________________ **Score:** ______________________

Reviewed by: ______________________ **Review Date:** ______________________

INSTRUCTIONS: The Instructions for the Denial File Reviews specify how many random files are to be pulled. Each file will be reviewed using the elements below and scored as follows: **"1"** if the information is present; **"0"** if the information is not present; or **"N/A"** if the information is not applicable to the file.

NOTE: In order to receive a full score of **"2"**, 90% (or 9 out of 10), of the files must meet the criteria. If less than 90% of the files meet criteria, a score of "0" will be given. If less than 10 files are reviewed, all files must meet the criteria in order to receive a full score.

	1	2	3	4	5	6	7	8	9	10	File Audit Score
File Type: Routine = (PN), Urgent = (PU), Retrospective (PS)											
Date Request Received											
Date of Decision											
Date of Initial Notification											
Date of Written Confirmation											
NCQA UM 4: Professional Review of Clinical Information Qualified licensed health professionals assess the clinical information used to support UM decisions.											
1. There is evidence that a physician conducts a review on every denial decision for medical appropriateness and benefit coverage.											
2. There is evidence that the member is given alternative direction for follow-up care when a service is denied (Possible evidence of NCQA QI 10 Element D)											
NCQA UM 5: Timeliness of UM Decisions The PMG/IPA makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation.											
1. Decision time standard is met.											
2. The PMG/IPA notifies the practitioner of the decision of requests within the appropriate timeframe.											

IPA Name: ____________________

	1	2	3	4	5	6	7	8	9	10	File Audit Score
3. The PMG/IPA provides written notification regarding denial decisions of requests within the appropriate time frames to the following:											**Ave:**
a. To the member											
b. To the practitioner											
SB59: The practitioner is initially notified within 24 hours of the decision either by telephone or fax											
1. The PMG/IPA notifies the practitioner initially by phone or fax, within 24 hours of the decision.											
NCQA UM 6: Medical Information When making a determination of coverage based on medical necessity, the managed care organization obtains relevant clinical information and consults with the treating physician.											
1. There is evidence that the PMG/IPA consistently gathers relevant clinical information to support UM decision-making.											
NCQA UM 7: Denial Notices The PMG/IPA clearly documents and communicates the reasons for each denial.											
1. The PMG/IPA notifies the practitioner that a physician will be available to discuss determinations based on medical appropriateness.											
2. The PMG/IPA clearly documents the reason for the denial in the written notification. The notification includes specific utilization review criteria or benefits provisions used in the determination:											**Ave:**
a. To the member											
b. To the practitioner											
3. The PMG/IPA includes information about the appeal process in denial notifications:											**Ave:**
a. To the member											
b. To the practitioner											
4. The PMG/IPA includes information on how to initiate an expedited appeal for urgent or concurrent denials at the time of notification:											**Ave:**
a. To the member											
b. To the practitioner											

IPA Name: ______________________________

	1	2	3	4	5	6	7	8	9	10	File Audit Score
5. Written notification contains notification that the Member and Practitioner can obtain a copy of the criterion.											
Medi-Cal Managed Care Division (MMCD) All Plan Letter No. 04006 & No. 05005 & SB59											
1. The IPA utilizes the "Your Rights" form:											**Ave:**
a. Approved template											
b. Correct Line of Business											
2. The IPA includes the "Form to File A State Hearing" for Medi-Cal denials.											
3. The notice of action letters must be a Health Plan/DHCS approved denial letter and include:											**Ave:**
a. Ombudsman contact information (Medi-Cal)											
b. DMHC information with TTY and website information											
c. Health Plan address & Member Services phone number											
d. Health Plan approved denial/modification letter											
H & S 1274.30, 1274.31, 1274.32, 1274.33 and AB 55											
1. The denial letter includes the DMHC required IMR language when treatment has been denied as not medically necessary or experimental.											
COMMENTS:											

INLAND EMPIRE HEALTH PLAN

INLAND EMPIRE HEALTH PLAN
SECOND OPINION TRACKING LOG

IPA Name: ______________________________ 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

INLAND EMPIRE HEALTH PLAN

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
ENDO – Fine Needle Aspiration of Thyroid	10021-10022
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

Procedure	**CPT Code**
GYN – Urine Pregnancy Test	81025
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
Hematology – Blood Smears	86007-85008
Nephrology – Urinalysis	8100-81003
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
Injection of Bursa	20600, 20605, 20610
Podiatry – Matrixectomy	11750
Podiatry – Debridement of Nails	11720-11721
Pulmonary – Spirometry	94010, 94060
Pulmonary – Blood Gases	82800-8210
Radiology - Mammogram	77057
- Breast Ultrasound @ radiologist suggestion	76645
- Cone View	77055
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 – Urinalysis	81000-81003
Urology - Cystoscopy	52000

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[Provider Organization Logo]

YOUR RIGHTS
(*SUS DERECHOS*)
UNDER MANAGED CARE
(*BAJO LA ADMINISTRACIÓN DE CUIDADO A LA SALUD*)

You may appeal this decision. This notice tells you how. It also tells you where to go to get help, including free legal help. (*Usted puede apelar esta decisión. Esta notificación le dice como hacerlo. También le dice a donde ir para recibir ayuda, incluyendo ayuda legal gratuita.)*

If you do not agree with this decision, you may (*Si usted no está de acuerdo con esta decisión, usted puede*):

- File a grievance with your health plan. See "Grievance" section. (*Presentar una queja con su plan de salud. Vea la sección "Quejas".*)
- Ask for an "Independent Medical Review (IMR) See "Independent Medical Review" section. (*Pedir una Revisión Medica Independiente (IMR) - siglas en inglés) Vea la sección "Revisión Medica Independiente"*)

You may have to file a grievance with your health plan **before** you can ask for an IMR, except in some cases. (***Puede ser que usted*** *tenga que presentar una queja con su plan de salud* ***antes*** *de que usted pueda pedir una Revisión Medica Independiente, excepto en algunos casos*)

You will not have to pay for any of these services. (*Usted no tendrá que pagar por ninguno de estor servicios.*

GRIEVANCES (*QUEJAS*)

You may ask for a grievance by:

- Calling IEHP at 1-800-440-IEHP (4347)/TTY 1-800-718-4347, or
- Fax your grievance to (909) 890-2168, or
- Send a letter to P.O. Box 19026, San Bernardino, CA 92423-9026, or
- In person at 303 East Vanderbilt Way, Suite 100, San Bernardino, CA 92408, or
- Via the IEHP Web site at www.iehp.org.

Your doctor will have grievance forms. IEHP will review its decision based on your grievance and you will get an answer within 30 days. If you think that waiting 30 days will harm your health, be sure to say why when you ask for your grievance. Then you might be able to get an answer within 72 hours.

(*Usted puede presentar una queja:*

- *Llamando a IEHP al -800-440-IEHP (4347)/TTY 1-800-718-434,7 o*
- *Por fax al (909) 890-2168, o*
- *Envíe una carta al P.O. Box 19026, San Bernardino, CA 92423-9026, o*
- *En persona al 303 East Vanderbilt Way, Suite 100, San Bernardino, CA 92408, o*
- *Por la red de Internet de IEHP al www.iehp.org.*

Su doctor tiene formularios de quejas. IEHP revisará su decisión basado en su queja y usted recibirá una respuesta dentro de 30 días. Si usted piensa que esperar 30 días perjudicará su salud, asegúrese de decir la razón cuando presente su queja. Entonces, es posible que usted obtenga una respuesta dentro de 72 horas)

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You have the right to submit to IEHP written comments, documents, or other information relevant to your grievance. (*Usted tiene el derecho de proveer a IEHP comentarios escritos, documentos, u otra información referente a su queja)*

You have the right to choose anyone to file your grievance for you, including parents, guardians, conservators, relatives, or other designee. In addition, you have the right to have anyone you appoint represent you during the grievance process. (*Usted tiene el derecho de escoger a cualquier persona para que presente su queja por usted, incluyendo padres, tutores, conservadores, familiares, u otra persona designada. Además, usted tiene el derecho de seleccionar a cualquier persona para que lo represente durante el proceso de queja).*

EXPEDITED REVIEW (URGENT GRIEVANCE) (REVISIÓN RÁPIDA (QUEJA URGENTE))

You have the right to an expedited review and resolution of your urgent grievance within 72 hours, if the normal time frame for the decision making process would be detrimental to your life, or health or jeopardize your ability to regain maximum functions. An urgent medical condition involves imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb, or major bodily function. This also includes services you are currently receiving. You can call IEHP at 1-800-440-IEHP (4347)/TTY 1-800-718-4347 and request an expedited review of your grievance. (*Usted tiene el derecho a una revisión rápida y resolución a su queja urgente dentro de 72 horas, si su condición medica envuelve una seria amenaza a su salud, incluyendo, pero sin ser limitado a dolor severo, el potencial de la pérdida de su vida o una función mayor del cuerpo. Esto también incluye servicios que todavía está recibiendo. Usted puede llamar a IEHP al 1-800-440-IEHP(4347)/TTY 1-800-718-4347 y pedir una revisión urgente de su queja.)*

DEPARTMENT OF MANAGED HEALTH CARE (DMHC – siglas en inglés) (*DEPARTAMENTO DE ADMINISTRACIÓN DE CUIDADO MÉDICO*)

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(1-800-440-IEHP (4347)/TTY 1-800-718-4347)** and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online."
*(El Departamento de Administración de Cuidado Médico es responsable de regular los planes de servicio de cuidado de salud. Si tiene una queja contra su plan de salud, debe de llamar primero a su plan de salud, IEHP al (***1-800-440-IEHP (4347)/TTY 1-800-718-4347***) y usar su proceso de resolución de quejas antes de comunicarse con el Departamento. Utilizando el proceso de quejas del plan no le previene el uso de cualquier otro remedio provisto por la ley. Si tiene una queja que envuelve una emergencia, una queja que no ha sido resuelta satisfactoriamente por el plan, o su queja sigue sin resolución por mas de 30 días, usted puede*

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*llamar al Departamento para asistencia. También puede que usted sea elegible para una Revisión Medica Independiente. Si su caso es elegible para una Revisión Medica Independiente, el proceso proveerá una revisión imparcial de las decisiones medicas hechas por un plan de salud relacionado con el servicio o tratamiento propuesto para él cuidado médico que sé esta necesitando, las decisiones de cobertura para terapia o tratamiento experimental o de investigación y aclarara el conflicto financiero para servicios urgentes o de emergencia. El Departamento tiene un número de teléfono gratuito **(1-888-HMO-2219)** y para las personas con impedimentos auditivos y del habla pueden usar el **(1-877-688-9891)** para comunicarse con el Departamento. La red del Internet del Departamento **(http://www.hmohelp.ca.gov)** tiene los formularios de quejas y las instrucciones disponibles en línea.)*

INDEPENDENT MEDICAL REVIEW (IMR) (REVISIÓN MEDICA INDEPENDIENTE (IMR) - siglas en inglés)

You may ask for an IMR if you believe that your item or service was incorrectly denied (*Usted puede pedir un IMR si usted cree que el articulo o servicio fue negado incorrectamente*).

Ask for your IMR (*Pida un IMR)*:

- 30 days after you file a grievance with IEHP, (*30 días después de que presente su queja con IEHP, o*) or
- as soon as your grievance is denied, if that comes sooner. (*Tan pronto como su queja sea negada, si esto pasa primero).*

The eligibility for IMR is as follows (*La elegibilidad para un IMR es la siguiente*):

1. Your Doctor recommended a health care service as medically necessary (*Su Doctor recomendó u servicio medico como médicamente necesario*); or
2. You have received urgent care or emergency services that a provider determined was medically necessary (*Ud. ha recibido servicio de urgencia o de emergencia que un proveedor determinó que era médicamente necesario)*; or
3. You have been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which you seek an independent medical review (*A Ud. se le ha visto por un proveedor dentro del plan por una diagnosis o tratamiento de la condición medica para la que Ud. solicita un IMR)*; or
4. The disputed health care service has been denied, modified, or delayed by IEHP or one of its contracting providers, based in whole or in part on a decision that the health care service is not medically necessary (*Los servicios disputados han sido negados, modificados, o demorados por IEHP o uno des sus proveedores afiliados, todo o en parte porque el tratamiento no es médicamente necesario)*; or
5. You have filed a grievance with IEHP and IEHP has determined to agree with the denial decision or your grievance remains unresolved for 30 days. (*Ud. ha sometido una queja con IEHP y IEHP esta de acuerdo con la decisión de negar el servicio medico o su queja se mantiene sin resolver por mas de 30 días).*

If your grievance requires expedited review, you may immediately submit your grievance to the Department of Managed Health Care (DMHC). (*Si su queja requiere revisión urgente, usted puede inmediatamente someter su queja a Departamento de Cuidados Médicos (DMHC)*)

You must ask for the IMR within 6 months after your grievance has been denied. (*Usted debe de pedir el IMR dentro de 6 meses después de que su queja fue negada).*

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- To ask for an IMR, call the Department of Managed Health Care (DMHC) at **1-888-466-2219**. If you have trouble hearing or speaking, call **1-877-688-9891 (TDD)**, or the California Relay Service at **1-800-735-2929 (TDD)** and www.IP-relay.com. (*Para pedir un IMR, llame al Departamento de Administración de Cuidado Medico (DMHC) – siglas en inglés) al **1-888-466-2219**. Si usted tiene problemas para oír o hablar, llame al **1-877-688-9891 (TDD)** o).*

The DMHC also has an Internet website with forms and instructions at (*El DMHC también tiene un sitio de Internet con formularios e instrucciones)* **http://www.hmohelp.ca.gov.**

EXPERIMENTAL INVESTIGATIONAL THERAPIES (TERAPIA EXPERIMENTAL O DE INVESTIGACIÓN)

EXTERNAL INDEPENDENT REVIEW (REVISIÓN INDEPENDIENTE EXTERNA):

If you qualify, you can request an external independent review for denied experimental or investigational therapy or treatment. To qualify your doctor must certify that you have a life-threatening or seriously debilitating condition for which (*Si usted califica, puede solicitar una revisión independiente externa por habérsele negado una terapia o tratamiento experimental o de investigación. Para calificar su doctor debe certificar que usted tiene una condición medical que amenaza su vida o que seriamente debilita su salud por la cual*):

- Standard therapies have not been effective in improving your condition (*Las terapias comunes no han sido efectivas para mejorar su condición*);
- Standard therapies would not be medically appropriate for you (*Las terapias comunes no serian médicamente apropiadas para usted)*; or
- There is no more beneficial standard therapy covered by IEHP than the therapy proposed by your doctor (*No hay otras terapias comunes disponibles que le serian beneficiales y que estuvieran cubiertas por IEHP, nada mas las que fueron propuestas por su doctor).*

You are not required to participate in IEHP's Grievance Process before requesting an independent review for experimental or investigational therapies. You may contact IEHP at 1-800-440-IEHP (4347) for more information regarding the external independent review process, or request an application form. (*Usted no está obligado a participar en el Proceso de Quejas de IEHP antes de pedir una revisión independiente para terapias experimentales o de investigación. Usted puede llamar a IEHP al 1-800-440-IEHP (4347) para mas información acerca del proceso de revisión independiente.)*

In addition to the External Independent Review, you have the right to request an IMR if your treatment is "experimental" or "investigational," or your health may be seriously harmed without it. You may ask for an IMR right away. See above information regarding the IMR process. (*Adicionalmente a su derecho a una revisión independiente, usted tiene derecho de pedir un IMR, si su tratamiento es "experimental", "de investigación", o su salud puede ser seriamente perjudicada sin el tratamiento. Usted puede pedir un IMR inmediatamente. Vea la información arriba acerca del proceso para IMR)*

If your case qualifies for an IMR, your medical records will be sent to an IMR doctor outside the health plan who will say whether he/she agrees that the treatment is necessary. You will receive the decision on your IMR within 30 days, or within 3 to 7 days if your treatment is "experimental," "investigational," or your health may be seriously harmed without it. (*Si su caso califica para un IMR, sus expedientes médicos serán enviados a un doctor fuera de su plan de salud quien dirá si el o ella está de acuerdo que el tratamiento es necesario. Usted recibirá la decisión acerca de su IMR dentro de 30 días, o dentro de 3 a 7 días si su tratamiento es*

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"experimental", "de investigación", o su salud puede ser perjudicada seriamente si no lo recibe.)

The DMHC is in charge of making sure all managed care health plans do what the law says they should do. You may call them with any complaints you have about us. (*El DMHC está encargado de asegurar que todos los planes de salud hagan lo que la ley dice que deben hacer. Usted puede llamarles con cualquier queja que tenga acerca de nosotros).*

OTHER INFORMATION (*OTRA INFORMACIÓN*)

IEHP wants to try to help you with your problem, so we hope you will call us first. (*IEHP quiere tratar de ayudarle con su problema, por lo tanto esperamos que usted nos llame a nosotros primero)*

CRITERIA USED TO MAKE THIS DECISION (PAUTA USADA PARA HACER ESTA DECISIÓN)

To obtain a free copy of the specific utilization criteria, benefits provisions, guideline, protocol, or other similar criterion used in this decision, please write or call: (Para una copia gratuita especifica del criterio de utilización, provisiones de beneficios, guias de protocolo, u otro criterio similar usado en esta decisión, por favor escriba o llame al:)

[IPA Name]
[IPA Address]
[IPA Phone Number]

HEALTH PLAN REFERRAL FORM
OUT-OF-NETWORK/SPECIAL SERVICES

THIS FORM IS FOR SERVICES REQUIRING HEALTH PLAN REVIEW

1. Referrals

DATE: ____________________	(TO BE COMPLETED BY IEHP) **AUTH/TRACKING NUMBER:** ____________________
❑ **URGENT/EXPEDITED** - Decision w/in 72 hours ❑ **ROUTINE** ❑ **PATIENT REQUESTED** ❑ **RETRO**	**AUTH/EXPIRATION DATE:** ____________________

2. GENERAL INFORMATION

Member Name (please print)	DOB	ID #

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

Address	City	Zip	Phone

Diagnosis (Required)	**ICD-9 Code (REQUIRED)**

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

Referred to **(must refer to a specialist within network)**	Specialty:	NPI#:	Phone
Address:	City:	Zip	Fax

Referring Provider (please print)	Phone	Fax

Address	City	Zip

Referring Provider Signature (REQUIRED)	NPI#	Date

3. SERVICE REQUESTED

Service Requested *(check one)*	❑ Consult	❑ Follow-up	❑ DME	❑ Home Health	❑ Other
Service Location/Facility:			❑ Office	❑ Outpatient	❑ Inpatient

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

Facility Address	Phone	Fax

4. COMPLETED BY IEHP

Date Additional Information Required:	Date Additional Information Received:	❑ Approved	❑ Modified	❑ Other

Assigned IPA:

Medical Reviewer Comments

Medical Reviewer Signature (Circle Title: MD, DO, RN, LVN, Coordinator)	Date	Criteria utilized in making this decision is available upon request by calling IEHP (866) 725-4347.

UPON ACCEPTANCE OF REFERRAL AND TREATMENT OF THE MEMBER, THE PHYSICIAN/PROVIDER AGREES TO ACCEPT IEHP CONTRACTED RATES. This referral/authorization verifies medical necessity only. Payments for services are dependent upon the Member's eligibility at the time services are rendered.

NOTICE: This facsimile contains confidential information that is being transmitted to and is intended only for use of the recipient named above. Reading, disclosure, discussion, dissemination, distribution, or copying of this information by anyone other than the named recipient or his or her employees or agents is strictly prohibited. If you have received this facsimile in error, please immediately destroy it and notify us by telephone at **(866) 725-4347, then 2.**

FAX COMPLETED REFERRAL FORMS TO (909) 890-5528