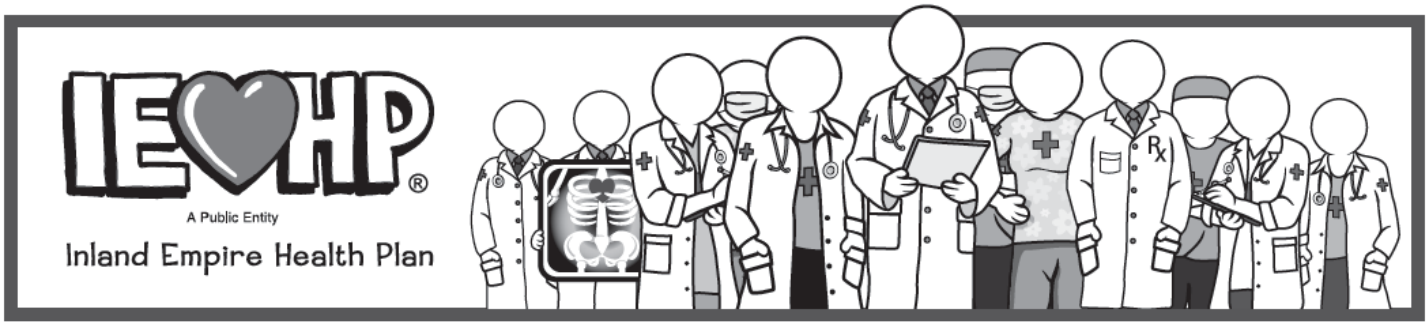

To: Home Health Providers

From: IEHP – Utilization Management

Date: May 13, 2019

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

Inland Empire Health Plan's Utilization Management (UM) department has experienced an increase in Home Health referrals received without the required documentation for the services requested.

To address this concern, we are testing a new ***Home Health Check Off List*** to use when submitting Home Health referrals.

The ***Home Health Check Off List*** does not replace clinical notes and should be used as a guideline when determining what notes are required.

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

Please begin using the ***Home Health Check Off List*** immediately.

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

As a reminder, all communications sent by IEHP can also be found on our Provider portal at the following address: https://www.iehp.org/en/providers/plan-updates.

Should you have any comments and/or questions please contact the Provider Relations Team at 909-890-2054.

Enclosure: Home Health Check Off List

A Public Entity
Inland Empire Health Plan

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

Home Health Agency Contact Information

Contact Person: _____

Contact Number: _____

CHECK ALL THAT APPLY:

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

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

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

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