Inland Empire Health Plan

Utilization Management Program Description

IEHP Medi-Cal & IEHP DualChoice (HMO SNP)

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Section 1: Utilization Management Program Overview

1.1. Mission

The mission of the Inland Empire Health Plan (IEHP) Utilization Management (UM) Program is to ensure that Members receive timely, appropriate, and medically necessary health services.[1]

1.2. Purpose

The purpose of the UM Program is to manage the health care services utilized by Members in a high-quality manner. Effective monitoring of medical practice patterns and utilization of healthcare services, include the following elements:

1. The mechanisms used to promote effective use of services in the areas of prior authorization, concurrent review, discharge planning and transitions of care, ambulatory care review, retrospective review, non-medical transportation, non-emergent medical transportation, and behavioral health care;
2. Ensuring adequate systems and resources are in place to provide comprehensive care at the appropriate level in the delivery of healthcare services by its employees and contracted entities; and
3. Ensuring that utilization management activities are performed in accordance with the California Health and Safety Code, Section 1367.01.

1.3. Objectives

IEHP has developed and implemented a plan of activities centered on the utilization of health care services and delivery to Members. An evaluation of program objectives and process is performed annually by the UM Subcommittee with revisions as directed by the Quality Management and Health Equity Transformation Committee (QMHETC). Specific objectives include:

1. Develop, implement, and distribute UM standards for all lines of business to contracted Providers as promulgated in the IEHP Provider Manuals;
2. Promote uniformity of UM activities for authorization, medical necessity determination, and Member notification of decisions among delegated Providers;
3. Provide oversight of behavioral health care services through coordination with the Behavioral Health and Care Management (BH & CM) Department for applicable lines of business;
4. Facilitate Member access to the healthcare delivery system by continuous assessment for barriers to care;
5. Develop structural standards for delegated UM activities including requirements for UM Plans, UM Committees, Medical Directors, out-of-area management, discharge planning and transitions of care, data collection, and reporting;

[1] Health Services – For the purpose of this program description, "Health Services" includes behavioral health services.

6. Assist the Delegation Oversight team, with monitoring activities assigned to Delegates through structured oversight functions including review of denials, grievances, appeals related to UM decisions, audits, and other activities;

7. Perform tracking activities and trending analysis on a wide variety of information including utilization data, denial of services or benefits, for patterns that may indicate restrictions in Member access to care;

8. Assure that authorized services are covered under the Member's health plan benefit;

9. Facilitate Member access to healthcare services consistent with the benefits according to their line of business without regard to race, ethnicity, religion, age, genetic information, national origin, mental or physical disability, sexual identity or orientation, or payment source;

10. Monitor utilization practice patterns of the IEHP health delivery network including practitioners, hospitals, ancillary services, and specialty Providers;

11. Provide a system to identify high-risk Members and assure that care is accessed through appropriate resources, including referral to BH & CM programs Health Education or Enhanced Care Management, as applicable;

12. In collaboration with the Provider Experience division, ensure that network Providers are trained on the timeframes and procedures for obtaining prior authorization for medically necessary services;[2]

13. Educate Members, Physicians, Hospitals, ancillary and specialty Providers about IEHP's goals for providing quality, value enhanced managed healthcare; and

14. Continually improve IEHP UM Subcommittee criteria based on outcome data and review of medical literature.

1.4. Scope

The UM Program encompasses all Members accessing medical or behavioral health services. The scope of the UM Program includes the following elements:[3]

1. The UM Program is designed to provide oversight for Members' utilization of healthcare services and benefits through the continuous monitoring of Delegates and Providers. The UM Program also monitors and provides education, support and direction for non-delegated UM activities administered by IEHP.

2. The UM Program is designed to ensure that compensation of individuals or entities that conduct UM activities are not structured to provide incentives to deny, limit, or discontinue medically necessary services;[4]

[2] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program
[3] National Committee for Quality Assurance (NCQA), Health Plan (HP) Standards and Guidelines, UM 1, Element A, Factor 5
[4] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program

3. The UM Program is designed to provide direction and consistency of UM activities throughout the IEHP network through adoption of UM Program standards, adoption of nationally recognized criteria, and education of Providers.

4. The UM Program assessment encompasses all UM activities and outcomes concerning IEHP Members including, but not limited to, primary care, specialty and behavioral health care Providers in all applicable care settings including emergency, inpatient, outpatient, and home health.

5. The UM Program evaluates the quality of UM activities including, but not limited to, barriers to health care, communication between Providers, and coordination and continuity of care.

1.5. Quality Management (QM) Responsibilities of the UM Program[5]

The UM Program monitors UM data and activities to identify potential quality of care issues. UM information relevant to QM is reported to the QMHETC through the UM Subcommittee.[6] Reports to the QMHETC may include readmission rates, standard UM metrics, as well as over and underutilization issues. The UM Subcommittee identifies, investigates, and monitors issues of concern related to the utilization and quality of services provided by the IEHP network as directed by the QMHETC. The UM Program includes continuous quality improvement processes that are coordinated with QM activities as appropriate.

Section 2: Utilization Management Lines of Authority and Responsibility

Lines of authority originate with the IEHP Governing Board and extend to Providers and participating Physicians. The Governing Board delegates responsibility for oversight and direction for processes affecting the delivery of health care for Members to the Chief Executive Officer (CEO), Chief Medical Officer (CMO), Medical Directors, and QMHETC. Further details can be found in the IEHP Organizational Chart.

2.1. UM Subcommittee

The IEHP QMHETC delegates responsibility for oversight and direction of the UM Program to the UM Subcommittee.

1. **Role:** The UM Subcommittee directs the continuous monitoring of all aspects of UM activities conducted by IEHP, its Delegates and Providers, including the development of appropriate standards administered to Members, with oversight by the Chief Medical Officer (CMO) or physician designee.[7]

2. **Function** - The following elements define the functions of the UM Subcommittee in maintaining quality, effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of health care services:

    a. Annual review and approval of the UM Program Description and applicable workplans;

[5] NCQA, HP Standards and Guidelines, UM 1, Element A, Factor 1
[6] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program
[7] NCQA, HP Standards and Guidelines, UM 1, Element A, Factor 3

b. Annual review of UM and BH policies, procedures, and criteria utilized in the evaluation of appropriate clinical and behavioral health care services, coordination, and continuity of care interventions;[8]

c. Review of UM trend and bed day utilization reports such as: average length of stay; bed days per thousand; admissions per thousand by category including: Skilled Nursing Facility (SNF); behavioral health care; non-specialty mental health services for both adult and pediatric Members; over and underutilization; outpatient utilization; Emergency Room (ER) visits; and UM-related appeals; [9]

d. Annual review of results and findings from interrater reliability surveys to ensure that UM decision-making is based only on the appropriateness of care and services, and that established criteria are applied consistently;

e. Annual evaluation of Member and Provider satisfaction with the UM process;

f. Review of proposed new technologies and new applications of existing technologies that are not primarily medication-related, and recommend these to the QMHETC for inclusion as an IEHP benefit;[10] and

g. Review of literature and set standards for non-preventive/preventive clinical care guidelines that are not primarily medication-related and recommend these to the QMHETC for approval.

Section 3: Utilization Management Personnel

Qualified staff are responsible for the UM program.[11] Their reporting relationships and position responsibilities can be found in the organizational charts.

3.1. Vice President, Medical Directors

The Vice President of Medical Directors is a board-certified Physician and holds an unrestricted license to practice medicine in the State of California. Under the direction of CMO, the Vice President of Medical Directors provides executive medical leadership across the Health Services Departments. This includes direct oversight and management of the Utilization Management medical directors as well as provision of clinical leadership and strategic direction across Health Services in partnership with the Vice President of Clinical Integration and Operations.

3.2. Vice President, Health Services Clinical Integration and Operations

The Vice President of Clinical Integration and Operations is a Registered Nurse and has the primary responsibility to plan, organize, direct, and coordinate the IEHP approach to an integrated and person-centered care model within the plan, including direct oversight and integration of multiple departments (Utilization Management, Behavioral Health & Care Management, and Pharmaceutical Services).

[8] NCQA, HP Standards and Guidelines, UM 1, Element A, Factor 2
[9] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.3, Review of Utilization Data
[10] NCQA, HP Standards and Guidelines, UM 10, Element B, Factor 1
[11] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program

3.3. Senior Medical Director

The Senior Medical Director is a board-certified Physician and holds an unrestricted license to practice medicine in the State of California. Under the direction of the Vice President of Medical Directors, the Senior Medical Director is responsible for clinical oversight and monitoring of all IEHP UM activities; direction for internal and external UM Program functions; and participation in QM functions.[12] In conjunction with Behavioral Health (BH) Physician Support, the Senior Medical Director is also responsible for the oversight of Plan-covered BH services. Principal accountabilities for the UM Program include:

1. Ensuring the process by which IEHP and its Delegates review and approve, partially approve (modify), delay, or deny, based in whole or in part on medical necessity, requests by Providers prior to, retrospectively, or concurrent with the provision of health care services to Members comply with State, Federal and contractual requirements;[13]
2. Ensuring the clinical accuracy of all coverage decisions made by IEHP and its Delegates that involve medical necessity;[14]
3. Ensuring that medical decisions are rendered by qualified medical personnel and are not influenced by fiscal or administrative management considerations;[15,16,17,18]
4. Ensure that medical and other health care provided meets acceptable standards of care;[19,20]
5. Ensure that IEHP and its Delegates' medical personnel follow medical protocols and rules of conduct;[21]
6. Ensuring timelines and processes do not impose Quantitative Treatment Limitations or Non-Quantitative Treatment Limitations more stringently on Plan-covered mental health and substance use disorder services than are imposed on medical/surgical services.[22,23]
7. Participation in Delegates' UM activities, as necessary;
8. Assisting the Delegation Oversight team, as needed, with monitoring and oversight of delegated UM activities including review of UM workplans, activities, processes, results and outcomes;

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[12] NCQA, HP Standards and Guidelines, UM 1, Element A, Factor 3
[13] California Health and Safety Code (Health & Saf. Code) § 1367.01
[14] Medicare Managed Care Manual, "Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance," Section 10.4.2
[15] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 1.1.6, Medical Director
[16] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program
[17] NCQA, HP Standards and Guidelines, UM 4, Element A, Factor 1
[18] Title 22, California Code of Regulations (CCR) § 53857
[19] 22 CCR § 53857
[20] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 1.1.6, Medical Director
[21] Ibid.
[22] Title 42 Code of Federal Regulations (CFR) § 438.900 et. seq
[23] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program

9. Review of current medical practices ensuring that medical protocols and all medical personnel of IEHP follow accepted medical standards;[24,25]
10. Ensuring the receipt of appropriate healthcare services and medical attention of Members at all locations;
11. Participation in staff training;[26]
12. Monitoring documentation for adequacy;[27]
13. Availability to UM staff on site or by telephone;[28]
14. Reviewing and approval of internal policies and procedures related to UM; and
15. Chairing the UM Subcommittee or designating a Chair, as needed.

3.4. Behavioral Health (BH) Physician Support

IEHP utilizes a Board-Certified Psychiatrist and Psychologist to support with the development and implementation of UM policies, case review, clinical oversight, and management of the BH aspects of the UM Program. [29]

3.5. Senior Director of UM Operations

The Senior Director of UM Operations is unlicensed and non-clinical, who reports to the Vice President, Health Services Clinical Integration and Operations. The Senior Director of UM Operations is responsible for the development and implementation of operational processes, policies and procedure adherence, and departmental regulatory compliance. The Senior Director of UM Operations is responsible for oversight of delegated and non-delegated UM activities, including prior authorization and letter review, as well as direction to non-clinical UM staff in support of clinical UM staff.

3.6. Senior Director of Integrated Transitional Care

The Senior Director of Integrated Transitional Care is a Registered Nurse who reports to the Vice President, Health Services Clinical Integration and Operations. The Senior Director of Integrated Transitional Care is responsible for the development and implementation of operational and clinical processes, policies and procedure adherence, and departmental regulatory compliance. The Senior Director of Integrated Transitional Care is responsible for oversight of inpatient and prior authorization for Specialty Programs, Care Transitions, and Long-Term Care.

3.7. UM Clinical and Non-Clinical Staff

Staff support of UM consists of clinical and non-clinical UM staff. The clinical staff includes Registered Nurses (RNs), Licensed Vocational Nurses (LVNs) and Social Workers with the required qualifications to perform UM in a managed care environment, such as experience in utilization management or care management. The non-clinical support consists of non-licensed UM coordinators with the required qualifications to

[24] 22 CCR § 53857
[25] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 1.1.6, Medical Director
[26] NCQA, HP Standards and Guidelines, UM 1, Element A, Factor 3
[27] Ibid.
[28] Ibid.
[29] NCQA, HP Standards and Guidelines, UM 1, Element A, Factor 4

support UM in a managed care environment. Staff positions include concurrent and long term care review nurses, discharge planning nurses, prior authorization nurses, care transitions specialists, inpatient and prior authorization coordinators, analysts, UM Nurse Managers and Nurse Supervisors.

Section 4: Annual Evaluation of Utilization Management Program

The Senior Medical Director, and Directors of Utilization Management evaluate the effectiveness and progress of the UM Program annually.[30] The UM Program Description and associated policies and procedures are reviewed at least annually and updated as needed. A yearly summary of all UM Program activities is documented with assistance from the Quality Management, Behavioral Health & Care Management and HealthCare Informatics (HCI) departments. The report includes a summary of UM activities, changes in criteria or program activities, documented barriers to care, monitoring results, and significant issues impacting health care provided to Members. The Senior Medical Director, and/or Directors of Utilization Management presents the UM Program Description and the annual evaluation to the UM Subcommittee for approval and then to the QMHETC for comment, suggested program adjustments, and revision of procedures or guidelines, as necessary. The yearly UM program summary is presented to the IEHP Governing Board for assessment of UM activities affecting the health care rendered to Members, comment, activities proposed for the coming year, and approval of changes in the UM Program.

Section 5: Member Benefits

Benefits for Members are mandated by the Department of Health Care Services (DHCS) for Medi-Cal Members and by the Centers for Medicare and Medicaid Services (CMS) for IEHP DualChoice Members. Evidences of Coverage for each line of business are maintained by Marketing.

Section 6: Clinical Criteria for BH UM and Medical UM Decisions

6.1. Clinical Criteria for UM Decisions

IEHP and its Delegates must use nationally recognized clinical criteria and/or IEHP UM Subcommittee-Approved Authorization Guidelines, when making decisions related to medical care.[31, 32] Criteria sets approved by IEHP include Title 22 of the California Code of Regulations, CMS National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and Local Coverage Articles (LCA), InterQual, Hayes Clinical Criteria, Apollo Managed Care Guidelines/Medical Review Criteria, Milliman Care Guidelines (MCG), DHCS Medi-Cal Provider Manual, DHCS All Plan Letters (APLs) and IEHP UM Subcommittee-Approved Authorization Guidelines.[33,34,35,36] IEHP may distribute additional criteria following approval by the UM Subcommittee.

[30] NCQA, HP Standards and Guidelines, UM 1, Element B
[31] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[32] NCQA, HP Standards, UM 1, Element A, Factor 6
[33] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[34] CA Health & Saf. Code § 1363.5(b)
[35] NCQA, HP Standards and Guidelines, UM 2, Element A, Factor 1
[36] NCQA, HP Standards and Guidelines, UM 1, Element A, Factors 5 & 6

1. **Development -** Clinical criteria guidelines that are developed by IEHP and used to determine whether to authorize, modify, or deny health care services are developed with involvement from actively practicing health care Providers.[37,38] The criteria or guidelines must be consistent with sound clinical principles and processes and must be evaluated at least annually and updated if necessary.[39,40] New or updated clinical criteria must be reviewed and approved by the UM Subcommittee. The UM Subcommittee obtains external independent review, whenever necessary to assist with the development of clinical criteria guidelines.

2. **Application -** IEHP and its Delegates must apply criteria in a consistent and appropriate manner based on available medical information and the needs of individual Members.[41] The application of criteria takes into consideration individual factors, such as age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment.[42] Decisions to deny services cannot be solely based on codes being listed as non-covered, i.e. Medi-Cal Treatment Authorization Request (TAR) and Non-Benefit list of codes. Additionally, application of criteria takes into consideration whether services are available within the service area, benefit coverage, and other factors that may impact the ability to implement an individual Member's treatment plan. The organization also considers characteristics of the local delivery system available for specific Members, such as:[43]

    a. Availability of services, including but not limited to skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the Member after hospital discharge;

    b. Coverage of benefits for skilled nursing facilities, subacute care facilities, home care where needed, Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS), Managed Long-Term Services and Support (MLTSS), Multipurpose Senior Services Program (MSSP), or Behavioral Health; and

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

    IEHP and its Delegates must ensure consistent application of UM criteria by following this specific order as IEHP or Delegate is licensed to use:[44,45]

[37] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[38] NCQA, HP Standards and Guidelines, UM 2, Element A, Factor 4
[39] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[40] CA Health & Saf. Code § 1363.5
[41] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[42] NCQA, HP Standards and Guidelines, UM 2, Element A, Factor 2
[43] NCQA, HP Standards and Guidelines, UM 2, Element A, Factor 3
[44] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[45] NCQA, HP Standards and Guidelines, UM 2, Element A, Factor 1

For Medi-Cal Line of Business:

a. IEHP Member Handbook (Evidence of Coverage); **then**

b. DHCS Medi-Cal Provider Manual **or** Title 22 of the California Code of Regulations (CCR) **or** DHCS All Plan Letters; **then**

c. National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium **or** IBM Watson Health Products: Micromedex; **then**

d. MCG Health Informed Care Strategies Care Guidelines; **then**

e. InterQual Criteria; **then**

f. Hayes Clinical Criteria; **then**

g. Apollo Medical Review Criteria Guidelines for Managing Care; **then**

h. IEHP Utilization Management (UM) Subcommittee Approved Authorization Guidelines **or** Pharmacy and Therapeutics (P&T Subcommittee Approved Prior Authorization Criteria.

For IEHP DualChoice Line of Business:

a. IEHP Member Handbook (Evidence of Coverage); **then**

b. Local Coverage Determination (LCD); **then**

c. Local Coverage Article (LCA); **then**

d. National Coverage Determination (NCD); **then**

e. Medicare Benefit Policy Manual; **then**

f. National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium **or** IBM Watson Health Products: Micromedex; **then**

g. MCG Health Informed Care Strategies Care Guidelines; **then**

h. InterQual Criteria; **then**

i. Hayes Clinical Criteria; **then**

j. Apollo Medical Review Criteria Guidelines for Managing Care; **then**

k. IEHP Utilization Management (UM) Subcommittee Approved Authorization Guidelines **or** Pharmacy and Therapeutics (P&T) Subcommittee Approved Prior Authorization Criteria.

3. **Annual Review and Adoption of Criteria -** IEHP develops and/or presents criteria to the IEHP UM Subcommittee for adoption and implementation. After approval by UM Subcommittee, the criteria are sent to the IEHP QMHETC for reference and disseminated to Delegates and Providers via letter, website or email. Members of the UM Subcommittee and practitioners in the appropriate specialty, review criteria annually with updates as necessary. [46,47]

[46] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures

[47] NCQA, HP Standards and Guidelines, UM 2, Element A, Factors 4 and 5

4. **Process for Obtaining Criteria-** IEHP discloses to Providers, Members, and Member's representatives, or the public, upon request, the clinical guidelines or criteria used for determining health care services specific to the procedure or condition requested.[48,49]

   a. Providers may obtain information about criteria, either in general or relating to specific UM decisions, from IEHP by contacting the IEHP UM Department.[50] Providers may also access and review IEHP UM Subcommittee Approved Authorization Guidelines from the IEHP website.

   b. Members may obtain criteria used as the basis for any health care service denial they have received by contacting IEHP Member Services Department.[51] IEHP Member Services staff relay the request to the UM Department for response to the Member.

   c. All requests for UM clinical criteria are logged and processed upon request. Every disclosure of information is accompanied by the following statement: "The materials provided to you are guidelines used to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on an individual need and the benefits covered under your Health Plan."[52]

5. **Annual Assessment of Consistency of UM Decisions (Inter-rater Reliability) -** IEHP evaluates, at least annually, the consistency with which health care professionals involved in utilization review appropriately apply criteria in decision making.[53,54] IEHP acts on identified opportunities to improve consistency.[55]

Section 7: Behavioral Health Care Services[56]

7.1. Behavioral Health Care Referral

IEHP, through its Behavioral Health and Care Management Department, uses DHCS-approved standardized screening tools to ensure Members seeking mental health services, who are not currently receiving Non-Specialty Mental Health Services (NSMHS) or Specialty Mental Health Services (SMHS) receive Closed Loop Referrals to the appropriate delivery system for mental health services, either within IEHP's Provider Network for NSMHS or the County Behavioral/Mental Health Department for SMHS.[57,58,59] Members can self-refer to therapy services in their respective counties. IEHP Member Services and/or Behavioral Health Department can assist Members desiring to self-refer

[48] CA Health & Saf. Code § 1365.5
[49] NCQA, HP Standards and Guidelines, UM 2, Element B, Factors 1 and 2
[50] CA Health & Saf. Code § 1363.5(b)(4)
[51] Ibid.
[52] CA Health & Saf. Code § 1363.5(c)
[53] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[54] NCQA, HP Standards and Guidelines, UM 2, Element C, Factor 1
[55] NCQA, HP Standards and Guidelines, UM 2, Element C, Factor 2
[56] NCQA, HP Standards and Guidelines, UM 1, Element A, Factor 2
[57] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.3.12, Mental Health Services
[58] DHCS Behavioral Health Information Notice (BHIN) 21-073 Supersedes BHIN 20-043 in part, "Criteria for Beneficiary Access to Specialty Mental Health Services, Medical Necessity and Other Coverage Requirements"
[59] NCQA, HP Standards and Guidelines, UM 1, Element A, Factor 5

and/or with accessing behavioral health services as needed. IEHP UM Program is responsible for ensuring that referral decisions are made according to protocols that define the level of urgency and appropriate setting of care. Referral protocols for behavioral health care services include the following:[60]

1. 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 care and substance use cases;
2. Referral staff members must utilize protocols and guidelines that are up-to-date and specifically address behavioral health care and substance abuse;
3. Staff must be provided appropriate education and training regarding use of the protocols;[61] and
4. Protocols provided to and used by staff are reviewed and/or revised annually.

7.2. Intensive Outpatient and Partial Hospitalization Programs

IEHP can authorize this level of service for IEHP DualChoice Members who are experiencing severe symptoms but not severe enough to require inpatient services. Intensive Outpatient Programs (IOPs) can be used to treat co-occurring mental health and substance use disorders when clinical criteria guidelines are met. Partial Hospitalization Programs (PHPs) can be used as an alternative or a step-down from an acute psychiatric inpatient facility. On a case-by-case basis, and in collaboration with County BH Department Medical Director(s), PHPs and IOPs and may be approved for Medi-Cal Members, when the Member is experiencing an eating disorder and/or treatment is medically necessary.

7.3. Acute Psychiatric Inpatient Services

IEHP can authorize inpatient services for IEHP DualChoice Members experiencing severe and acute symptoms relating to a behavioral health condition. On a case-by-case basis, and in collaboration with County BH Department Medical Director(s), inpatient services may be approved for Medi-Cal Members only when the Member is experiencing an eating disorder and treatment is medically necessary.

Section 8: Use of Appropriate Professionals for UM Decisions

8.1 IEHP Personnel Standards

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 adopted the following standards for personnel making review decisions and reviewing denials:[62, 63]

1. UM Technicians/Specialists/Coordinators can make eligibility determinations, review referral forms for completeness, interface with Provider offices to obtain any needed non-medical information,[64] and approval of authorizations, as determined appropriate (auto authorizations).

[60] NCQA, HP Standards and Guidelines, UM 1, Element A, Factor 2
[61] NCQA, HP Standards and Guidelines, UM 4, Element A, Factor 1
[62] NCQA, HP Standards and Guidelines, UM 4, Element A, Factor 2
[63] NCQA, HP Standards and Guidelines, UM 1, Element A, Factor 1

2. Licensed Vocational Nurses (LVNs) or contracted UM review staff can perform initial review of medical information, make the initial determination of benefit coverage, obtain additional medical information as needed from Provider offices,[65] approve referrals based on IEHP-approved authorization criteria, concurrent inpatient, and initiate denials for non-covered benefits and carve-outs.

3. Registered Nurses (RNs)/Licensed and Master Level BH Care Managers can perform initial review of medical information, initial determination of benefit coverage, obtaining additional medical information as needed,[66] from the Provider's office, approval of referrals based on medical necessity or IEHP-approved authorization criteria, and providing medical necessity recommendation to the physician reviewer.

4. Physician Reviewer - A designated board-certified physician, who holds an unrestricted license to practice medicine in the State of California must review all denials and partial approvals (modifications) based in whole or in part on medical necessity and obtain additional medical information from the treating physician as needed.[67,68,69,70] The reviewing Physician or other appropriate health care professional must have expertise in the field of medicine or health care that is appropriate for the services at issue, including knowledge of Medicare and Medicaid coverage criteria, before a decision is rendered. The physician or health care professional reviewing the request need not, in all cases, be of the same specialty or subspecialty as the treating physician or other health care provider.[71,72]

8.2 Use of Board-Certified 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, IEHP consults with Board-certified physicians in the appropriate specialty. [73] IEHP has created a Physician Specialty Review Panel and contracts with an external review company for these specialty consultations.[74]

Section 9: IEHP UM Authorization Process Standards

IEHP maintains written policies and procedures regarding the process to review, approve, partially approve (modify) or deny prospective, concurrent, or retrospective requests by Providers concerning the provision of health care services for Members. These policies and procedures are

[65] NCQA, HP Standards and Guidelines, UM 1, Element A, Factor 1
[66] Ibid.
[67] CA Health & Saf. Code § 1367.01(e)
[68] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[69] NCQA, HP Standards and Guidelines, UM 4, Element A, Factor 1
[70] NCQA, HP Standards and Guidelines, UM 4, Element C
[71] 42 CFR § 422.566(d)
[72] 42 CFR § 422.629(k)(3)
[73] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[74] NCQA, HP Standards and Guidelines, UM 4, Element F, Factor 1

available to the public through IEHP's website and upon request.[75,76] The information on how to obtain a copy of IEHP's Utilization Management processes is outlined in the Member's Evidence of Coverage.

9.1 Specialty Referral System

IEHP maintains a specialty referral system that tracks and monitors referrals requiring prior authorization. The system includes approved, partially approved (modified), denied and deferred referrals received from both contracted and non-contracted providers, as well as the timeliness of these referrals.[77]

9.2 System Controls

IEHP have system controls in place to protect data specific to denial and appeal notifications and receipt dates from being altered outside of prescribed protocols. [78]

9.3 Out-of-Network Services

Authorization and notification of decision for proposed services, referrals, or hospitalizations involve utilizing information such as medical records, test reports, specialist consults, and verbal communication with the requesting Provider. Part of this review process is to determine if the service, whether seldom used or an unusual specialty service, is available in network. IEHP may authorize and arrange for out-of-network access in the following circumstances:[79,80]

1. The Plan does not meet network adequacy requirements;[81]
2. The Plan does not have an Alternative Access Standards (AAS) approved by DHCS and fails to meet the network adequacy standards;
3. The Plan fails to comply with the requirements for timely access to appointment; or
4. When medically necessary long-term care is not available within the Plan's network.

IEHP and its delegates may also authorize and arrange for out-of-network access to afford Members their right to continuity of care per regulatory, statutory and contractual requirements.

9.4 Prior Authorization Requirements

The prior authorization process described in this policy do not apply to these services, which do not require prior authorization:

[75] CA Health & Saf. Code § 1363.5(a)
[76] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program
[77] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program
[78] NCQA, HP Standards and Guidelines, UM 12, Element A
[79] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.7, Out-of-Network Access
[80] NCQA, HP Standards and Guidelines, MED 1, Element D
[81] CA Welfare and Institutions Code (Welf. & Inst. Code), § 14197

1. Emergency services and services necessary to treat and stabilize an emergency medical condition; [82,83,84]
2. Family planning; [85,86]
3. Abortion services; [87]
4. Sexually transmitted infection (STI) services diagnosis and treatment; [88,89]
5. Sensitive and confidential services;
6. HIV testing and counseling at the Local Health Department;[90,91]
7. Immunizations at the Local Health Department;[92]
8. Routine OB/GYN Services, (including prenatal care by Family Care Practitioner (credentialed for obstetrics) within the IEHP Network;[93]
9. Initial mental health and substance use disorder assessments;[94]
10. Out of area renal dialysis;
11. Biomarker testing for advanced or metastatic stage 3 or 4 cancers[95,96]
12. Urgent Care;[97] and
13. Preventative services,[98] which includes the following services and those listed in the DHCS Medi-Cal Provider Manual Preventive Services List:[99]

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[82] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[83] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.2, Timeframes for Medical Authorization
[84] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.6, Access to Emergency Service Providers and Emergency Services
[85] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[86] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[87] DHCS APL 24-003 Supersedes APL 22-022, "Abortion Services"
[88] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[89] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[90] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[91] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[92] Ibid.
[93] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[94] Ibid.
[95] CA Health & Saf. Code § 1367.665
[96] DHCS APL 22-010 "Cancer Biomarker Testing"
[97] Ibid.
[98] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[99] DHCS Medi-Cal Provider Manual, "Preventive Services"

a. Bone Density Screening (CPT Codes: 77080 and 77081);

b. Diagnostic Mammograms for ages 40 and above (CPT Codes: 77065, 77066 and 77063);

c. Lung Cancer Screening (CPT Codes: S8032 and 71271).

14. Routine mental health services (group therapy, individual therapy and outpatient medication management) as long as the service is obtained from an in-network provider.

IEHP allows Members direct access to Specialists, appropriate for their condition and identified need for special healthcare needs. [100] IEHP ensures Members have access to American Indian Health Services Programs (AIHSP). AIHSP, whether or not contracted, can provide referrals directly to network Providers without first requesting a referral from a PCP.[101]

9.5 Medical Necessity Determination

IEHP determines medical necessity for a specific requested service as follows:[102]

1. IEHP employs IEHP-approved clinical criteria, as outlined in this policy and utilizes the following definitions for determining the medical necessity of a healthcare service:

   a. For individuals 21 years of age or older, a service is a "medical necessity" when it is reasonable and necessary to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attach, maintain, or regain functional capacity. [103,104]

   b. For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity," when the service is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services. [105]

   c. Medicare - Utilize a definition that is reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member,[106] or otherwise medically necessary under CMS; and

   d. Where there is an overlap between Medicare and Medi-Cal benefits (e.g. DME), the more generous definition of medical necessity will be applied.

2. In the interest of providing timely access to care, IEHP does not defer or pend authorizations due to lack of information. If information reasonably necessary to

[100] NCQA, HP Standards and Guidelines, MED 1, Element B, Factor 1
[101] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[102] NCQA, HP Standards and Guidelines, UM 1, Element A, Factor 5
[103] 22 CCR § 51303(a)
[104] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.2, Medically Necessary Services
[105] CA Welf. & Inst. Code § 14059.5
[106] Social Security Act § 1862 (a)(1)

make a determination is not available with the referral, IEHP contacts the requesting Provider for the additional clinical information by telephone at least two (2) times and with a third attempt being made by a Medical Director. The request for additional information must be annotated and include the date of request.[107,108] If, after making these attempts, IEHP is still not in receipt of all the information reasonably necessary and requested to make a determination within regulatory timeframes, IEHP must notify the Member and requesting Provider within the required timeframe, or as soon as the Delegate becomes aware that it will not meet the initial authorization timeframe, whichever is earlier using the "Notice of Action- Delay" template.. This notification shall include the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required, along with the anticipated date on which a decision may be rendered.[109]

3. IEHP considers all factors related to the Member including barriers to care related to access or compliance, impact of a denial on short and long-term health status of the Member and alternatives available to the Member if denied.

4. IEHP obtains input from appropriate specialists in the area of the health care services requested either through a UM Subcommittee member, telephonically, or use of an outside service.

9.6 Experimental and Investigational Determinations

The determination for all experimental and investigational services is the responsibility of IEHP.[110] All referral requests for experimental/investigational services must be sent to the IEHP Medical Director by facsimile using the Health Plan Referral Form for Out-of-Network and Special Services (see Provider Manual). The request must include all supporting clinical information as well as appropriate diagnosis and procedure codes. IEHP is responsible for decision-making and notifying the Provider, Member, and Delegate of the determination per standard timeframes for level of urgency.

1. If coverage is denied to a Member with a terminal illness, which for the purposes of this section refers to an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services or supplies deemed experimental, the Member and/or their authorized representative are offered the opportunity to request a conference, which shall be held within 30 calendar days or as early as five (5) business days (if requested by the prescribing physician) of the denial.[111]

9.7 Notifications

Communications regarding authorization requests will adhere to the following requirements:[112]

[107] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[108] NCQA, HP Standards and Guidelines UM 6, Element A
[109] CA Health & Saf. Code § 1367.01(5)
[110] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.8, Investigational Services
[111] CA Health & Saf. Code § 1368.1(a)
[112] CA Health & Saf. Code § 1367.01(h)

1. Decisions to approve requests shall specify the specific health care service approved.
2. Decisions to deny or modify health care services shall be communicated to the Member in writing, and to Provider initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include:[113, 114]
    a. Clear and concise explanation of the reasons for the decision;
    b. A description of the criteria or guidelines used; [115,116] and
    c. Clinical reasons for the decisions regarding medical necessity.

    Any decision to deny a service authorization based on medical necessity or to authorize a service that is less than requested in an amount, duration, or scope must be reviewed and approved by a UM Medical Director or physician designee.[117,118,119] Members and Providers must receive denial letters for any requested referral that is denied or modified.[120] The initial notification which is written communication to a Provider of a denial must include the name and telephone number of the UM Medical Director or designee responsible for the denial. [121,122] Such communication must offer the requesting Provider the opportunity to discuss with the physician reviewer issues or concerns regarding the decision.[123,124] This written notification of denial or partial approval (modification) must also inform the requesting Provider of the appeal process.[125,126]

Written notifications:

1. Are made available in IEHP's threshold languages;
2. Are written in a manner, format and language that can be easily understood;[127,128]
3. Include information on how to request for translation services and alternative formats; and

[113] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[114] CA Health & Saf. Code § 1363.5(b)(4)
[115] NCQA, HP Standards and Guidelines, UM 7, Element B, Factor 2
[116] NCQA, HP Standards and Guidelines, UM 7, Element E, Factor 2
[117] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[118] CA Health & Saf. Code § 1367.01(e)
[119] NCQA, HP Standards and Guidelines, UM 1, Element A, Factor 1
[120] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.1.5, Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests
[121] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[122] CA Health & Saf. Code § 1367.01
[123] NCQA, HP Standards and Guidelines, UM 7, Element A
[124] NCQA, HP Standards and Guidelines, UM 7, Element D
[125] NCQA, HP Standards and Guidelines, UM 7, Element C
[126] NCQA, HP Standards and Guidelines, UM 7, Element F
[127] NCQA, HP Standards and Guidelines, UM 7, Element B, Factor 1
[128] NCQA, HP Standards and Guidelines, UM 7, Element E, Factor 1

4. For written notifications of a denial or modification, information on the Member's right to appeal the decision, file a grievance and request an administrative hearing (for Medi-Cal Members).[129,130]

Section 10: Other UM Program Requirements

10.1. Rescinding or Modifying Authorization

Any authorization provided by IEHP or its Delegate must not be rescinded or modified after the Provider has already rendered the health care service in good faith pursuant to the authorization. [131]

10.2. Continuity of Care

IEHP ensures Members with pre-existing provider relationships who make a Continuity of Care (COC) request are given the option to continue treatment for up to 12 months with an out-of-network provider per DHCS requirements.[132]

10.3. Standing Referrals

A PCP may 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 an extended access to a Specialist or specialty care center for a Member who has a life threatening, degenerative, or disabling condition that requires coordination of care by a Specialist. [133,134]

10.4. Second Opinions

IEHP provides for its Members second opinion from a qualified health professional within the network at no cost to the Member or arranges for the Member to obtain a second opinion outside of the network, if services are not available within the network.[135,136]

10.5. Vision Services

IEHP is responsible for UM activities associated with Vision Services for applicable lines of business. Ophthalmology requests must be submitted through the UM prior authorization process.

10.6. Communication Services

IEHP provides access to staff for Members and Providers seeking information about the UM process and the authorization of care by contacting Member or Provider Services. This includes the following:

[129] NCQA, HP Standards and Guidelines, UM 7, Element C
[130] NCQA, HP Standards and Guidelines, UM 7, Element F
[131] CA Health & Saf. Code § 1371.8
[132] DHCS-IEHP Primary Operations Contract, 1Exhibit A, Attachment III, Provision 5.2.12, Continuity of Care
[133] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program
[134] CA Health & Saf. Code § 1374.16
[135] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program
[136] NCQA, HP Standards and Guidelines, MED 1, Element C

1. IEHP maintains telephone access for Providers to request authorization for healthcare services through the Provider Relations Team.[137]

2. IEHP UM Staff are available at least eight (8) hours a day during normal business hours (8:00 AM – 5:00 PM) Monday through Friday, to receive phone calls regarding the UM process or issues. The toll-free numbers are (800) 440-4347 for Medi-Cal and (877) 273-4347 for IEHP DualChoice. IEHP staff can accept collect calls regarding specific cases and UM decision inquiries.[138] Communications received after normal business hours will be returned on the next business day.

3. IEHP's Nurse Advice Line service is available after hours to receive inbound communication.[139]

4. Outbound communication from staff regarding inquiries about UM are made as needed during the hours of 8:00 AM and 6:30 PM Monday through Saturday.

5. Staff identifies themselves by name, title, and organization when initiating or returning calls regarding UM issues.[140]

6. There is a toll free TDD/TTY number, (800) 718-4347, for Members who are deaf, hard of hearing or speech-impaired.[141]

7. Language assistance is available for Members to discuss UM issues.[142]

10.7. Record Retention

IEHP retains records relating to prior authorization requests, including any Notices of Action for a minimum period of 10 years.[143]

10.8. Documentation of Medical Information and Review Decisions

IEHP bases its 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.[144]

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

2. **Reviewer Documentation** - Reviewers must abstract and maintain review process information in written format for monitoring purposes. Decisions must be based on clinical information and sound medical judgment with consideration of local standards of care. 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. Documentation must also include a written

[137] CA Health & Saf. Code § 1367.01
[138] NCQA, HP Standards and Guidelines, UM 3, Element A, Factor 1
[139] NCQA, HP Standards and Guidelines, UM 3, Element A, Factor 2
[140] NCQA, HP Standards and Guidelines, UM 3, Element A, Factor 3
[141] NCQA, HP Standards and Guidelines, UM 3, Element A, Factor 4
[142] NCQA, HP Standards and Guidelines, UM 3, Element A, Factor 5
[143] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[144] NCQA, HP Standards and Guidelines, UM 1, Element A, Factor 6

assessment of medical necessity, relevant clinical information, appropriateness of level of care, and the specific criteria upon which the decision was based.

3. **Documentation** - IEHP logs requests by date and receipt of information so that compliance with timeframes can be tracked. Documentation of authorizations or referrals 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 also includes a written assessment of medical necessity, relevant clinical information, appropriateness of level of care, and the specific criteria upon which the decision was based. All referrals must be signed by the requesting physician and dated. The Medical Director or physician designee must sign any denial of a proposed service or referral in the medical management system.[145]

10.9. Inpatient Stay

The utilization management process for inpatient stays must include:

1. Determining medical necessity;
2. Determining appropriate level of care;
3. Coordinating with hospital Case Manager's discharge plan.

10.10. Discharge Planning and Care Coordination

The UM process must include the following activities related to discharge planning:

1. Determining level of care (SNF, custodial care (if applicable), office visit, home health, home without services);
2. Arranging necessary follow-up care (home health, follow-up PCP or specialty visits, etc.);
3. Facilitating transfer of the discharge summary and/or medical records, as necessary, to the PCP office; and
4. Continuity and coordination (including transition) of care across all patient care settings.

10.11. Repatriation

IEHP manages Members that access care out of network. This includes assisting with the transfer of Members, as medically appropriate, back into the IEHP network during an inpatient stay.

10.12. Non-Discrimination

All Members must receive access to all covered services without restriction based on race, color, ethnicity, ethic group identification, national origin, ancestry, language, religion, sex, age, mental or physical disability or medical condition, gender, gender identity, sexual orientation, claims experience, medical history, claims history, evidence of insurability

[145] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures

(including conditions arising out of acts of domestic violence), genetic information, marital status, or source payment.

10.13. Confidentiality

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

10.14. Affirmative Statement Regarding Incentives

UM decisions for Members must be based only on appropriateness of care and service.[146] IEHP ensures that compensation for individuals or entities that conduct utilization management activities are not structured to provide incentives to deny, limit or discontinue medically necessary services.[147] Practitioners and employees/staff who make utilization-related decisions need to be concerned about the risks of underutilization. The Affirmative Statement about incentives is distributed annually to all practitioners, providers, and employees involved in authorization review, as well as Members.

10.15. Economic Profiling

Economic profiling is defined as any evaluation performed by the physician reviewer based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician reviewer. Delegates that engage in economic profiling must document the activities and information sources used in this evaluation and ensure that medical decisions are rendered, unhindered by fiscal and administrative management.[148,149,150,151]

10.16. Prohibition of Penalties for Requesting or Authorizing Appropriate Medical Care

Physicians cannot be penalized in any manner for requesting or authorizing appropriate medical care.

Section 11: Grievance and Appeal Process

IEHP maintains a formal Grievance Resolution System to ensure a timely and responsive process for addressing and resolving all Member grievances and appeals.[152] The Member may file a grievance or appeal by phone, by mail, fax, website, or in person. For further details regarding investigation of grievances/appeals and the time frames for resolution, please refer to internal Grievance and Appeals policies and procedures.

Section 12: New Technology

IEHP evaluates the inclusion of new technologies and the new application of existing technologies

[146] NCQA, HP Standards and Guidelines, MED 9, Element D, Factor 1
[147] DHCS-IEHP Primary Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program
[148] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 1.1.5, Medical Decisions
[149] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program
[150] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3, Utilization Management Program
[151] CA Health & Saf. Code § 1367.02
[152] NCQA, HP Standards and Guidelines, UM 1, Element A, Factor 1

in its benefits plan, including medical and behavioral healthcare procedures, pharmaceuticals, and devices.[153] The QMHETC directs the Utilization Management (UM) and Pharmacy and Therapeutics (P&T) Subcommittees to ensure the appropriate evaluation and implementation of new technologies and new applications of existing technologies.

Section 13: Monitoring Activities and Oversight

IEHP maintains responsibility of ensuring that Delegates continue to be in compliance with all applicable State and federal laws and other requirements set forth by the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and the National Committee for Quality Assurance (NCQA).[154,155] For information on the monitoring and oversight activities performed by IEHP on its Delegates, please see Provider policy 14A, "Utilization Management – Delegation and Monitoring." The following describes IEHP's internal UM program monitoring and oversight activities:

1. **Review of UM Data** - The collection, reporting, and analysis of UM data related to Medi-Cal and IEHP DualChoice Members include internally generated reports as well as specific Delegate UM reports. Significant monthly variations suggesting over or underutilization in any of the reported data components are reviewed with IEHP Senior Medical Director, , and UM Directors.[156] Comparisons are performed by IEHP's UM Directors, CMO, and Medical Directors with summary reports reviewed by the UM Subcommittee on a quarterly basis.

    a. UM reports must include, at a minimum, the following:

        1) Enrollment;
        2) Member months;
        3) Acute bed days/1000;
        4) Number of admissions/1000;
        5) Average Hospital LOS;
        6) Re-admissions within 30 days of discharge;
        7) SNF bed days;
        8) Total number of prior authorization requests;
        9) Total number of denials;
        10) Denial percentage;
        11) Emergency encounters/1000;
        12) Disease-specific over and under utilization metrics.

        The above data must be presented in summary form to the UM Subcommittee for review and analysis.

[153] NCQA, HP Standards and Guidelines, UM 10, Element A, Factors 1-4
[154] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 3.0, Providers, Network Providers, Subcontractors, and Downstream Subcontractors
[155] DHCS APL 23-006 Supersedes APL 17-004, "Delegation and Subcontractor Network Certification"
[156] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.3, Review of Utilization Data

b. Monthly report (Universe) of all prior auth requests to include denials modifications, approvals, cancelled or withdrawn requested services;

c. Monthly report of all second opinion requests by Members;

d. Monthly report of all requests for expedited initial organization determinations (applies to IEHP DualChoice line of business only);

e. Presentation of selected data from above to PCPs, specialists, or Hospitals as a group or individually, as appropriate; and

f. Evidence of review of data listed above by the UM Subcommittee for trends by physicians for both over and underutilization.

2. **Satisfaction with the UM Process:** At least annually, IEHP performs Member and Provider Satisfaction Surveys as a method for determining barriers to care and/or satisfaction with IEHP processes, including UM, with subsequent implementation of actions for improvement as applicable.

   a. **Provider Satisfaction Survey:** A Provider Satisfaction Survey is conducted annually by a third-party vendor. For details on IEHP's Provider Satisfaction Survey, please refer to internal Quality Systems policies and procedures.

   b. **Member Satisfaction Survey:** IEHP utilizes the Consumer Assessment of Health Plans Survey (CAHPS®) for Member Satisfaction as administered through a third party, NCQA-certified data collection vendor. For details on IEHP's Member Satisfaction Survey, please refer to internal Quality Systems policies and procedures.

Section 14: Enforcement/Compliance

Enforcing compliance with IEHP UM standards is a critical component of monitoring and oversight of Delegates and practitioners, particularly related to delegated activities. Delegates that demonstrate a consistent inability to meet standards can be subject to contract termination.

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