Imperial Health Plan of California, Inc

and

Imperial Health Holdings Medical Group, Inc.

Provider Manual 2024

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SECTION 1. INTRODUCTION

1.1 Imperial Health Plan of California, Inc., and Imperial Health Holdings Medical Group, Inc.,

Imperial Health Plan of California, Inc., ("Imperial-HMO") is a health care service plan licensed in California in accordance with the Knox-Keene Health Care Service Plan Act of 1975, as amended with a select network of contracted providers based in numerous counties throughout California. Imperial Health Holdings Medical Group, Inc., ("Imperial-RBO") is a risk-bearing organization licensed in California in accordance with the Knox-Keene Health Care Service Plan Act of 1975, as amended. In the Provider Manual, Imperial-HMO and Imperial-RBO are collectively referred to herein as "Imperial."

Imperial is overseen by an executive board, a Chief Medical Officer and a Quality Management Committee, and other committees that oversee the care provided to Imperial's members.

1.2 Quality Management Committee

The Quality Management Committee is central to our business and oversees Utilization Management (UM) and Quality Management (QM) functions.

UM staff is familiar with pre-authorization processes required by Imperial's current policy and procedure. Imperial's policy is to expedite referral requests from providers by processing them within 1-2 working days. UM responsibilities include:

- Implementation of UM Program and Work Plan;
- UM reporting required for Imperial;
- Preparation for and participation in Imperial UM audits;
- Hospital Case Management;
- After-hours triage; and
- Other services as required by Imperial Insurance Companies, Inc. (IIC), regulatory agencies, and the National Committee for Quality Assurance (NCQA).

QM staff monitors the quality of care provided by Imperial providers and conducts quality assessment studies. QM responsibilities include:

- Implementation of QM Program and Work Plan;
- Practice pattern profiling and analysis;
- QM studies and reports required by Imperial;
- Preparation for and participation in Imperial QM audits;
- Member complaints and grievances resolution;
- Clinical provider complaints and grievances;
- Credentialing and re-credentialing process; and
- Other services as required by Imperial, regulatory agencies, and the NCQA.

1.3 Provider Network Operations

Provider Network Operations (PNO) is committed to being accessible to all contracted providers daily. Representatives are responsible for answering providers' questions, addressing their concerns, and assisting with a resolution.

PNO shall work with contracted providers to ensure all providers have the necessary information, resources, and assistance to work with Imperial. PNO responsibilities include:

- Provider Orientation to cover operations for Customer Service, UM, Claims, Eligibility, Imperial rosters, and QM;
- Provider Manual distribution;
- Issue resolution involving authorizations, claims, eligibility, capitation, and contracting;
- Provider education and training;
- Network updates;

- Distribution of health education material;
- Member enrollment issues;
- Provider complaints; and

- Assistance with grievances. The PNO department is available Monday through Friday from 8:00 a.m. to 5:00 p.m. (PST). Our contact information is as follows:

  • Phone: (800) 830-3901

  • Email: pnm@imperialhealthholdings.com

1.4 Credentialing

The Credentialing Department maintains provider credentialing files in compliance with standards recognized and mandated by the NCQA, Imperial, and other accrediting agencies.

1.5 Enrollment and Eligibility

The Enrollment and Eligibility Department processes eligibility lists (electronic or paper) for Imperial, prepares and mails eligibility lists to Primary Care Providers (PCPs), and administers and reconciles eligibility.

1.6 Claims and Encounter Data Processing

The Claims and Encounter Data Processing Department adjudicates, reviews, analyzes, and pays claims, compiles claims timeliness reporting, participates in claims audits, and processes encounter data for Imperial reports.

SECTION 2. IMPORTANT CONTACT NUMBERS

2.1 Imperial Contact Numbers

Main Number	(626) 838-5100
Main Fax	(626) 626-521-6028
Eligibility Department	(800) 708-7903

UM Phone	(800) 708-8273 (626) 838-5100
UM Fax	(626) 283-5021 Outpatient Fax (888) 901-2526 Inpatient Fax

Case Management	(800) 708-8273 (626) 838-5100

Claims Department	(800) 778-9302
Claims Forwarding Address	IHPCA: PO Box 60874 Pasadena, CA 91116 IHHMG: PO Box 60075 Pasadena, CA 91116
Claims Payer ID (Electronic Submission)	IHCA Office Ally: IHP01 IHHMG Office Ally: IMMG

Contracting/Provider Services	(800) 830-3901
Contracting/Provider Service Fax	(214) 452-1190

2.2 Other Contact Numbers

PCPs may also contact the Centers for Medicare and Medicaid Services (CMS) for additional information.

MS: For verification of eligibility for Medicare patients and managed care members, call the toll-free line at: (800) MEDICARE or (800) 633-4227.

SECTION 3. RESPONSIBILITIES OF IMPERIAL'S CONTRACTED PROVIDERS

3.1 Medical Services Covered under Primary Care

The following services are covered under PCP services unless special prior arrangements have been made with Imperial. Please refer to your Provider Agreement with Imperial for more information regarding coverage provisions. Covered medical services include all services a PCP customarily makes available to patients of his or her own practice, including but not limited to the services listed below:

- Maintain office accessibility to members during normal business hours (8:00 am to 5:00 p.m.) Monday through Friday, exclusive of federal holidays;
- PCPs are required to arrange for and provide 24/7 on-call coverage for all enrolled managed care members unless previous arrangements have been made with Imperial;
- First point of contact care for persons with previously undifferentiated health concerns;
- Office visits and examinations (diagnosis treatment of illness and injury);
- Adult health maintenance;
- Periodic health appraisal examination, including all routine tests performed in PCP's office;

- Routine gynecological examinations including pap smears;
- Venipuncture and administration of injections and injectables;
- Minor office surgical procedures, including repair of simple lacerations to areas other than the face, ear lavage, I&D of superficial soft tissue abscess, EKG, visual acuity testing, trigger point injections, arthrocentesis, etc.;
- Specimen collection;
- Nutritional counseling;
- Interpretation of laboratory results;
- Miscellaneous supplies related to treatment in PCP's office (i.e., bandages, arm slings, splints, suture trays, gauze, tape, and other routine medical supplies);
- Telephone consultations;
- Coordination of other health care services as they relate to member care;
- Immunizations, for adults and children, in accordance with accepted medical practice in the community; and
- Health education in disease prevention, exercise, and healthy living practices.

The following table lists services which are generally considered primary care services. PCPs must have received appropriate training, within the limitations of scope of practice, and consistent with state and federal rules and regulations. The following guidelines are based on routine uncomplicated cases where care is ordinarily provided by a PCP; they are not intended to be all inclusive and should be used with clinical discretion.

Allergies and Immunology	
• Treat seasonal allergies • Treat hives • Treat chronic rhinitis • Allergy history • Environmental counseling	• Minor insect bites/stings • Asthma, active with or without co-existing infection • Allergy testing and institute immunotherapy (if appropriately trained) • Administer immunotherapy
Adult Cardiology	
• Perform electrocardiograms. • Interpret electrocardiograms. • Evaluate chest pain. • Evaluate and treat coronary risk factors, including smoking, hyperlipidemias, diabetes, hypertension	• Evaluate and treat uncomplicated hypertension, CHF, stable angina, non-life-threatening arrhythmias • Evaluate single episode syncope (cardiac) • Evaluate benign murmurs and palpitations

Dermatology	
• Treat acne (acute and recurrent) • Treat painful or disabling warts with topical suspensions, electrocautery, liquid nitrogen. • Diagnose and treat common rashes including: contact dermatitis, dermatophytosis, herpes genitalis, herpes zoster, impetigo, pediculosis, pityriasis rosea, psoriasis, scabies, seborrheic dermatitis, and tinea versicolor • Screen for basal or squamous cell carcinomas. • Biopsy suspicious lesions (if trained may do biopsy of suspicious lesions for cancer or others such as actinic keratoses) • Punch biopsy • Incisional biopsy	• Diagnose and treat common hair and nail problems and dermal injuries. • Common hair problems include: fungal infections, ingrown hairs, virilizing causes of hirsutism, or alopecia as a result of scarring or endocrine effects • Common nail problems include: trauma, disturbances associated with other dermatoses or systemic illness, bacterial or fungal infections, and ingrown nails • Dermal injuries include: minor burns, lacerations, and treatment of bites and stings • Counsel patients regarding removal of cosmetic (non-covered) lesions. • Identify suspicious moles
Endocrinology	

• Diabetic management, including Type I and Type II, for most patients. • Patient education • Supervision of self-blood glucose monitoring (SBGM) testing • Medication management • Manage diabetic ketoacidosis (DKA) • Manage thyroid nodules (testing, radiological imaging)	• Diagnose and treat thyroid disorders • Identify and treat hyperlipidemia • Diet instruction • Exercise instruction • Provide patient education for osteoporosis risk factors • Identify and treat lipid disorders with diet and/or at least two medications for a minimum of six months
Gastroenterology	
• Diagnose and treat lower abdominal pain • Diagnose and treat acute diarrhea • Occult blood testing • Perform flexible sigmoidoscopy • Diagnose and treat heartburn, upper abdominal pain, hiatal hernia, acid peptic disease • Evaluate acute abdominal pain	• Diagnose and treat uncomplicated inflammatory bowel disease • Diagnose jaundice • Diagnose and treat ascites • Diagnose and treat symptomatic, bleeding or prolapsed hemorrhoids • Manage functional bowel disease • Manage diagnosed malabsorption syndrome • Manage mild hepatitis A
General Surgery	
• Evaluate and follow small breast lumps in teenagers • Order screening mammograms • Aspirate cysts • Foreign body removal	• Laceration repairs (minor) • Local minor surgery for hemorrhoids • Minor surgical procedures • Diagnose gallbladder disease • Manage inguinal hernia
Geriatrics	
• Diagnose and treat impaired cognition (dementia) • Be familiar with effects of aging on drug distribution, drug metabolism, and drug-drug interaction	• Management of advanced illness including the use of alternative levels of care • Recognition of elder abuse

Obstetrics and Gynecology (OB/GYN)	
• Perform routine pelvic exams and PAP smears • Perform lab testing for sexually transmitted diseases (STDs) • Wet mounts • Diagnose and treat vaginitis and STDs • Contraceptive counseling and management • Normal pregnancy (if physician privileged to deliver)	• Evaluate lower abdominal pain to distinguish gynecological from gastrointestinal causes • Diagnose irregular vaginal bleeding • Diagnose and treat endometriosis with hormone therapy • Manage premenstrual syndrome with non-steroidal anti-inflammatory hormones and symptomatic treatment
Neurology	

• Diagnose and treat all psychophysiological diseases, headaches, low back pain, myofascial pain syndromes, neuropathies, radiculopathies, and central nervous system (CNS) disorders • Diagnose and treat tension and migraine headaches • Order advanced imaging procedures (MRI or CT scan at an appropriate anatomic level after an appropriate clinical evaluation and trial of conservative therapy)	• Diagnose and management of syncope • Treat seizure disorders • Manage degenerative neurological disorders with respect to general medical care (e.g., Parkinson's) • Manage stroke and uncomplicated TIA patients • Lumbar puncture • Treat myofascial pain syndromes
Ophthalmology	
• Perform thorough ophthalmologic history including symptoms and subjective visual acuity • Perform common eye related services > Distant/near testing > Color vision testing > Gross visual field testing by confrontation > Alternate cover testing > Direct fundoscopy without dilation > Extraocular muscle function evaluation > Red reflex testing in pediatric patients	• Remove corneal foreign bodies (except metallic) • Treat corneal abrasions • Perform tonometry • Diagnose and treat common eye conditions: > Viral, bacterial, and allergic conjunctivitis > Blepharitis > Hordeolum > Chalazion > Subconjunctival hemorrhage > Dacryocystitis
Orthopedics	
• Treat low back pain and sciatica without neurological deficit • Treat sprains, strains, pulled muscles, overuse symptoms • Treat acute inflammatory conditions • Chronic knee problems • Manage chronic pain problems	• Diagnose and treat common foot problems (ingrown nails, corns/calloses, bunions) • Closed emergency reduction of dislocation (digit, patella, shoulder) • Treatment of minor fractures • Arthrocentesis
Otolaryngology (ENT)	
• Treat tonsillitis and streptococcal infections • Perform throat cultures • Evaluate and treat oropharyngeal infections > Stomatitis > Herpangina > Herpes simplex • Treat acute otitis media • Treat effusion	• Evaluate tympanograms/audiograms • Treat acute and chronic sinusitis • Treat allergic or vasomotor rhinitis • Remove ear wax • Treat nasal polyps • Diagnose and treat acute parotitis and acute salivary gland infections • Treat nasal obstruction (including foreign body) • Treat simple epistaxis

Physical Medicine and Rehabilitation	
• Coordinate care for patients recovering from major trauma or CNS injury by appropriate use of various rehab professionals including PT, OT, ST, and physiatrist	• Basic understanding of effective use of common orthotic and prosthetic devices including wrist splint for CTA, AFO for foot drop
Psychiatry	

• Perform complete physical and mental status examinations and extended psychosocial and developmental histories when indicated by psychiatric or somatic presentations (fatigue, anorexia, over-eating, headaches, pains, digestive problems, altered sleep patterns, and acquired sexual problems)	• Diagnose physical disorders with behavioral manifestation • Provide maintenance medication management after stabilization by a psychiatrist or if longer-term psychotherapy continues with a non-physician therapist • Diagnose and manage child, elder, dependent adult abuse, and domestic violence victims

Pulmonology	
• Diagnose and treat asthma, acute bronchitis, pneumonia • Diagnose and treat chronic bronchitis • Diagnose and treat chronic obstructive pulmonary disease	• Manage home aerosol medications and oxygen • Work up possible tuberculosis or fungal infections • Treat opportunistic infection • Order chest x-rays, special views, and CT scans
Rheumatology	
• Diagnose and treat non-articular musculoskeletal problems: > Overuse syndromes > Injuries and trauma > Soft tissue syndromes > Bursitis or tendonitis • Provide steroid injections • Manage osteoarthritis unless there is a significant functional impairment despite treatment	• Diagnose crystal diseases • Perform arthrocentesis • Diagnose and treat rheumatoid arthritis • Diagnose and treat inflammatory arthritic diseases • Diagnose and treat uncomplicated collagen diseases
Urology and Nephrology	
• Diagnose and treat initial and recurrent urinary tract infections (UTIs) • Provide long term chemoprophylaxis • Diagnose and treat urethritis • Explain hematospermia • Initiate evaluation of hematuria • Evaluate incontinence • Evaluate male factor infertility and impotence and treat readily correctable factors	• Diagnose and treat epididymitis and prostatitis • Differentiate scrotal or peri testicular masses from testicular masses • Evaluate prostatism and prostatic nodules • Manage urinary stones • Evaluate and treat renal failure • Placement of urinary catheters • Evaluate impotence • Evaluate male infertility
Vascular Surgery	
• Diagnose abdominal aortic aneurysm • Diagnose and treat venous diseases • Treat stasis ulcers	• Manage intermittent claudication • Manage transient ischemic attacks • Manage asymptomatic bruits
Other	
• Basic life support • Advanced life support • Heimlich maneuver	• Endotracheal intubation • Tracheostomy (emergency) • Cardiopulmonary resuscitation (CPR)

3.2 Role of Specialty Care Physicians

Specialty care physicians (specialists) provide referral services, consistent with industry standard medical practices, to Imperial members upon request by the PCP with authorization from Imperial. Specialists are responsible for communicating results and findings back to referring PCPs for continuity and/or coordination of care. Specialists are responsible for the following:

- Provide medically necessary specialty care authorized by Imperial;
- Work in conjunction with PCPs to assure continuity of patient care;
- Make authorization requests through referring PCPs;
- Submit treatment plans to PCPs and Imperial for continued specialty care;
- Assist PCPs and Imperial in coordinating ancillary services and hospitalization;

- Arrange for practice coverage by another Imperial contracted/participating physician for periods of unavailability (e.g., vacation, jury duty, holidays, illness, etc.);
- Provide and arrange for 24/7 on-call coverage for all managed care members; and
- Participate in respective UM/QM committees and programs as may be required under contract.

NOTE:

Specialists can only submit referral authorization requests, through the PCP, for additional continued care or treatment of members and cannot refer members to other specialists. Unauthorized services will not be reimbursed.

Specialists must notify Imperial to arrange for a Memorandum of Understanding to be in place when a non-participating provider is scheduled to take calls for the specialist or assist the specialist with a service or procedure. The use of a call answering machine is not an acceptable form of on-call coverage.

3.3 Appointments and Services

The following are standards and requirements for appointments and services rendered by PCPs as required by Imperial, CMS, and/or other regulatory agencies, including State Health and Human Services (HHS).

Type of Appointment and Services	Access Standards and Requirements
PCP Availability	• PCP must be available by telephone 24/7. • If the PCP is unable to provide on-call services, arrangements must be in place to cover the PCP after hours and on weekends; covering physician must be credentialed by Imperial.
Appointment Scheduling Systems	• Providers should use an efficient and effective written or computerized appointment scheduling system, which includes follow-up on canceled appointments.
In-Office Waiting Time	• The waiting time for scheduled appointments should be reasonable and within community standards.
Appointments for Urgent and Routine Primary Care Services	• For **urgent primary care services**, PCPs are required to triage and provide **same-day appointments** for members. • For routine primary care services, the maximum timeline for appointments is as follows: 1. Physical exams and routine preventive services: 4 work weeks. 2. Routine ambulatory visits: 7 business days.
Appointments for Routine Physician Consultations and Specialty Referrals	• Specialists must schedule an appointment for non-urgent, properly authorized referrals within 15 calendar days.
Appointments for Routine Prenatal Care	• Members in their first or second trimester: initial appointments must be available within one week from the date of the member's request. • Members in their third trimester and/or identified as "high risk": initial appointments must be made within 3 days of the member's request.
90-day Initial Health Assessment (IHA)	• Each newly enrolled member is expected to receive an IHA within 90 days of enrollment.

Type of Appointment and Services	Access Standards and Requirements
Appointment for Sensitive Services	• Sensitive services must be made available to members within two days of the member's request for appointment. Sensitive services include services related to mental or behavior health, sexual and reproductive health, sexually transmitted infections, substance abuse, gender-affirming care, and intimate partner violence. • Sensitive services will be provided under the following conditions: 1. For minors 12 years of age and older: without necessity of preauthorization, referral, or parental consent. 2. For all members: confidentially, in a manner that respects the member's privacy and dignity.

3.4 Telephone Access

PCPs, specialists, or office staff must return any non-urgent phone calls to members within 24 hours. Urgent and emergent calls are to be handled by the PCP according to Federal Regulations or State HHS standards, 24/7, unless prior arrangements have been made with Imperial.

3.5 Services for Members with Disabilities

PCPs and specialists must comply with all provisions of the Americans with Disabilities Act (ADA), including a handicapped bathroom or alternative access equipped with handrails, a handicapped access ramp, a handicapped water fountain or alternative provisions, an elevator (when applicable), and at least one handicapped parking space.

TDD/TTY Access for the Hearing Impaired in California is 711.

3.6 Interpreter Services

- PCPs and specialists are required to offer interpreter services to members with Limited English Proficiency (LEP) to provide quality health care services.
- Members should not be asked to use their own interpreters or to use family, friends, or minors to interpret.
- If a member declines interpreter services, the provider must note this in the member's medical record.
- Imperial providers must provide interpreter services 24/7 through IIC's AT&T or other contracted language lines. Providers can access language lines if requested by the member in his/her language. After-hours phone services staff should be instructed on how to connect with the language line.
- If a patient has LEP and requires language assistance, contact (855) 886-2901.
- See section 9.2 for additional information on the Language Assistance Program and Culturally and Linguistically Appropriate Services requirements.

3.7 Credentialing and Facility Site Review

Imperial contracted providers must be credentialed in accordance with guidelines set forth in Imperial's credentialing policies and procedures and as required by other applicable regulatory agencies or accrediting bodies. Acceptance of a provider into Imperial is contingent upon successful completion of the credentialing process. Additionally, PCPs participating in Medicare managed care must

pass facility site reviews conducted by Imperial. Continued participation with Imperial is dependent upon successful completion of the re-credentialing process that takes place every three (3) years.

The following documents are required for the initial credentialing process:

- Provider Profile;
- Pay to W-9;
- State Credentialing Release; and
- Supervisor Agreement (Medical Doctors only).

In addition, the following criteria are incorporated into the re-credentialing process:

- Member complaints;
- Information from quality improvement activities; and
- Member satisfaction.

A. Provider Status Change

State HHS departments and CMS mandate that members be notified of any provider status change 30 days prior to the change, or in cases of emergency, within 14 days of the change.

Any planned change in status, such as an address or phone number change, malpractice insurance coverage, or staffing changes must be reported immediately to Imperial.

B. Required Reporting

If any of the following events occur, Imperial must file with the State medical board (or other relevant state licensing agency) and report to the National Practitioner Data Bank (NPDBa) within 15 calendar days after the effective date of the action:

- The applicant's application for Imperial participation status (credentialing) is denied or rejected for a medical disciplinary cause or reason;
- The provider's participation status is terminated or revoked for a medical disciplinary cause or reason;
- Restrictions are imposed or voluntarily accepted for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason;
- The provider resigns or takes a leave of absence from Imperial; or
- Imperial participation status changes following notice of any impending investigation based on information indicating medical disciplinary cause or reason.

Imperial must notify the provider in writing of any adverse action taken. A contracted provider may request a fair hearing if there has been a reduction, termination, or suspension of the provider's contractual relationship.

C. Providers Rights

As a provider you have the following rights:

- Review the information submitted to support your credentialing application.
- Correct erroneous information from other sources.
- Receive status of your credentialing or re-credentialing application upon request.

3.8 Hospital Admissions and Admitting Staff

A contracted PCPs must have admitting privileges with a contracted-network hospitals that is geographically close to the office where the PCP practices medical care. The Admitting Team should always be notified by PCPs for assistance and coordination of care whenever an Imperial member is admitted. The Imperial Chief Medical Officer, or his or her designee, must be promptly notified (i.e. within 24 hours of admission) when an Imperial member is admitted to an acute care facility so that he (or she) can provide follow-up care.

3.9 Medical Records

PCPs are responsible for maintaining a legible, detailed, confidentially stored, easily retrievable medical record for each patient for ten (10) years, as required and mandated by CMS. Patient medical records are confidential documents used by

Release of medical information and records will be in accordance with Federal, State, and local statutes.

A. Confidentiality

Medical records will be stored in an area of medical practice with access limited to authorized staff only. All staff members must sign a Confidentiality Statement assuring that access to medical records and the information therein is confidential, and that this information may not be released without permission, nor can it be sold in total or in part.

All patient information is confidential and must be protected from disclosure to unauthorized personnel in accordance with the Federal HIPAA Act of 1996 regulations and applicable State laws. Patient information includes the patient's name, address, telephone number, social security number, or CHP or STAR identification number.

B. Standard Requirements

The following requirements apply to ALL Medical Records:

- A separate medical record is maintained for each patient;
- The medical record is to be stored in a secured place;
- Each medical record will contain at a minimum:
    - Complete patient name
    - Date of birth
    - Gender
    - Marital Status
    - Home address and phone number
    - Employer address and phone number (if applicable)
    - Insurance and member identification number
    - Signature on file for consent to treatment
    - Member's Primary Language;
- All pages in the medical record must contain the patient's name or identification number;
- All entries are dated and signed by the author (full signature and title are required);
- All entries must be dated and signed or initialed by the provider; and
- The medical record must be legible to others besides the provider and their staff.

C. Notation Requirements

A notation must be made in the medical record for each visit and must include:

- The date of the visit;
- The patient's chief complaint;
- A documented physical exam relevant to the complaint;
- A diagnosis and/or impression;
- A medication list that includes medication history and current medications;
- Medication allergies, adverse reactions, or the absence of known allergies, noted in a consistent fashion;
- A problem list that includes medical conditions and significant illnesses and surgeries;
- A comprehensive health history (for patients seen three or more times).

For children and adolescents under 18 years old, the history includes:

- Prenatal and perinatal care;
- Childhood illnesses; and
- Surgeries.

For patients over 14 years old, use of tobacco, alcohol, and substance abuse are documented for patients seen more than three times.

Progress notes must document the following:

- Height, weight, and vital signs;
- The patient's chief complaint;
- Unresolved problems from previous visits;
- A physical exam consistent with the chief complaint; and
- A working diagnosis;
- Tests, referrals, consults, and a plan of treatment consistent with working diagnosis;
- Prescribed medications include name of drug, dosage, and administration frequency, and duration;
- Follow up plan and date of return visit or PRN; and
- Health education and preventative care.
- Telephone advice is documented
- The physician initials and dates consultant summaries, laboratory, and other diagnostic reports. Consultant summaries and abnormal lab and diagnostic test results have a chart entry including a follow up care plan
- Immunization records appropriate to age are initiated on all patients
- Preventive screening and health education services are offered
- Problems lists are updated with each visit and unresolved problems are addressed at the next visit.
- Missed appointments are to be documented in the medical record. At a minimum, three attempts will be made to determine the cause of the missed appointment.
- Documentation includes a notation of the time and method used to contact the member
- Refusal to have a translator outside of family and or friend must be documented
- Any access to care problems is to be documented in the medical record

3.10 Vaccine and Immunization Administration

Vaccines for Medicare Advantage HMO members shall be the PCP's sole responsibility. Please refer to the PCP Agreement for reimbursement information.

SECTION 4. DATA AND CLAIMS SUBMISSION

4.1 Claims Submission

Industry standards require that all claims be submitted within 60 calendar days, or as defined in your provider services agreement following the end of the month, and no later than 90 days from when care was rendered. Claims will be processed, and payments made in accordance with the Timeliness Guidelines promulgated pursuant to the CMS Medicare Program. Claims should be submitted to Imperial for services performed by the physician according to the contract. Imperial will only accept claims submitted on an industry standard CMS 1500 or UB04 Claim Form.

For Imperial to accurately adjudicate claims and ensure timely processing and payment for services rendered to IMPERIAL members, it is imperative that all information required on the CMS 1500 is provided. Imperial will review all claims submitted to ensure that the billed level of care is consistent with the level of care authorized by Imperial and/or the service level of care provided with proper documentation. In the event a higher level of care is billed, Imperial will pay based on the authorized level of care.

The following minimum information must be on all CMS 1500 claims to be considered a "clean claim," otherwise the claim may be pending or denied:

- Patient's name and date of birth;
- Patient's insurance identification number;
- Patient's complete address;
- Date of onset of illness or injury (or last menstrual period where applicable);
- ICD-10 diagnosis code(s) and procedure and modifier code(s) (CPT or HCPCS);

- Referring physician;
- Date(s) of service, place of service, type of service, quantity/unit of service(s), and normal charges;
- Authorization number in Box 23 (when required);
- The Physician's Federal Tax ID number, Medicare Provider number, and NPI number (where applicable);
- Name and address of facility where services were rendered;
- Name, address, zip code, and phone number of Physician submitter;
- Attached OR, ER notes and medical reports for E&M codes billed as complex or severe;
- A copy of the authorized referral attached to the claim (when required); and
- EOMB or EOB attached if other coverage (COB) applies.

All billable services and claims must be submitted on the respective CMS 1500 or UB-92 form for services rendered. Superbills are not acceptable as claims for reimbursable services (e.g., non-capitated services, etc.) Send ALL claims to the following address:

Imperial Health Plan of California, Inc.

Claims Department
PO Box 60874
Pasadena, CA 91116-6874

Imperial Health Holdings Medical Group, Inc.

Claims Department
PO Box 60075
Pasadena CA 91116

Providers can sign up for the Office Ally website at www.officeally.com or by calling (866) 575-4120.

Imperial Health Plan of California Office Ally payer code is: IHP01

Imperial Health Holdings Medical Group Office Ally payer code is: IHHMG

Please refer to the Compensation Fee Schedule within your Provider Agreement to determine the payment amount you will receive for services rendered. All payable claims shall be processed in accordance with the applicable fee schedules and guidelines promulgated by each government program. Medicare Advantage HMO claims shall be paid in accordance with the prevailing Medicare fee schedule and the claims processing and payment guidelines as established by CMS.

Special services that cannot be identified with the appropriate CPT or HCPCS codes shall undergo Imperial's medical review and, if allowable, will be processed in accordance with the reimbursement rates generally provided in the community where care was provided.

To access Medicare's fee schedule, providers may visit http://www.cms.gov/Medicare/Medicare.html

(Refer to Section 12.3 Claims Settlement & Grievance Practices for information regarding claim disputes).

PROVIDERS MUST SUBMIT ENCOUNTER DATA FOR ALL MEMBER ENCOUNTERS, WHETHER THE ENCOUNTER IS CAPITATED OR FEE FOR SERVICE. FAILURE TO SUBMIT THIS DATA MAY IMPACT REIMBURSEMENT.

SECTION 5. ENROLLMENT AND ELIGIBILITY

5.1 Eligibility Verification

Providers must verify patient eligibility before providing any service. Possession of a membership card DOES NOT guarantee eligibility.

- Providers are encouraged to check eligibility of Medicare members by calling Imperial directly.
- Always try to find the member's name on the most recent Imperial. Eligibility List (E-List). The E-List can be accessed in the EZ-NET Provider Portal.

Reminder: Balance billing of any HMO member who is enrolled and eligible for covered services at the time the health care service were provided is expressly prohibited by federal and state law and Imperial's provider agreement.

5.2 Eligibility List

Member eligibility is available on the provider portal at
https://portal.imperialhealthholdings.com/EZ-NET60/Login.aspx.

5.3 Member Disenrollment

After open enrollment occurs, Medicare Advantage members are locked into the Plan of choice for 12 months.

Medicare Advantage SNP members have the option to change Plans on a month-to-month basis. PCPs are encouraged to promptly establish a patient-physician relationship with all Imperial members to promote continuity of care and to address and promptly resolve any health care needs or concerns of the patient.

5.4 Provider Status Change

Any planned change in status—such as a change in address, phone number, malpractice insurance coverage, or staffing—must be reported immediately, and at least thirty (30) days prior to the change, to Imperial's Credentialing Department.

SECTION 6. REFERRALS

6.1 Referral Authorization Process and Guideline

PCPs are responsible for obtaining an authorization when referring a patient for specialty services. (Refer to the Forms Section 17 for General Referral Form).

Specific Specialty physician services are covered only when properly authorized. PCPs should initiate authorization requests for the initial referral, and specialists should initiate authorization requests for follow-up services with the same specialist. If the patient requires a specialist-to-specialist referral (e.g., an orthopedist wants to refer a patient to a neurologist), the specialist may refer the patient directly to the new specialist and communicate the referral to the patient's PCP. PCPs and specialists should use a provider within Imperial's panel. Fax authorization request forms to:

Imperial Health Plan of California or
Imperial Health Holdings Medical Group,
Inc., Attn: UM Department
Phone: (800) 708-8273
Fax: (626) 283-5021

In accordance with NCQA standards, Imperial's UM staff and medical directors who make or supervise utilization related decisions base medical coverage decisions only on the clinical appropriateness of care and service.

Imperial does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of

coverage or service. In addition, there are no financial incentives for Utilization Management decision makers, and Imperial does not encourage decisions that result in underutilization.

6.2 Referral Submission Process for Routine and Urgent Referrals

Use Imperial's provider portal to submit online referrals. Please upload pertinent clinical documentation (e.g., progress notes, diagnostic test results, medications, and treatments for medical necessity reviews). For provider portal support and assistance, please contact (800) 830-3901.

General Referral Form in Section 14 can be used and may be faxed to Imperial's UM Department at (214) 452-1905. The following information must be provided to avoid unnecessary delays:

- Member's name;
- Member ID number;
- Specialist's name;
- Reason for referral (provide all pertinent progress notes which may include diagnostic test results, medications or treatments tried);
- Number of visits requested; and
- CPT and ICD-10 codes.

6.3 Guidelines on Authorization Turn-Around Time

Urgent Request Definition: an "urgent request" is one in which the enrollee's condition is such that the enrollee 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, such that the *normal* timeframe for the decision-making process would be detrimental to the enrollee's life or health.

Medicare Part C

Citation from CMS MMCM Chapter 13 Parts C & D Enrollee Grievances, Organization/Coverage Determination and Appeals Guidance 40.10 Processing Timeframes

Type	Processing Timeframe	With Extensions*
Standard Pre-Service	14 Calendar Days	28 days (non-contracted only)
Standard Part B Drug	72 hours	N/A
Retrospective	30 Calendar days**	N/A
Expedited Pre-Service	72 Hours	17 days
Expedited Part B Drug	24 hours	N/A

**14-day extension if the enrollee requests the extension or if the MA plan justifies a need for additional information and documents how the delay is in the best interest of the enrollee. MA plan must notify enrollees in writing if extension is going to be taken and explain the reason for the delay. Note: Part B drug and payment timeframes cannot be extended. See: 42 CFR §422.568(b)(1) and (2).*

6.4 Approved Referrals

Once a referral request is approved, Imperial's UM Department will notify the PCP and Specialist via fax and send a letter to the patient/member. If the referral is an urgent request, the UM department will also notify the member by phone.

It remains the responsibility of the PCP's office to notify the patient once the referral has been approved. The PCP must ensure that the name, address, and phone number of the specialist are given to the patient.

The PCP must also track and record the member having kept the appointment with the specialist, date, and time.

6.5 Denied Referrals

Imperial's UM Department will mail a letter to the patient and the provider informing them of any denial and providing information on the Appeal Process.

The UM department also sends a copy of the denial letter to the PCP, including the medical policy criterion for the denial. The PCP must file this letter in the member's medical record.

The referral may be denied for one of the following reasons:

- Member is not eligible with Imperial;
- Service requested is not a covered benefit;
- Service requested is the responsibility of the PCP;
- Medical necessity could not be established; or
- Service is carved-out to another entity.

Please Note: If the information provided on the referral form is not sufficient to determine medical necessity, a letter requesting additional information will be sent to the Requested Provider. The missing information may be:

- Lab or other diagnostic test results;
- Additional family or personal health history; or
- Consultation or progress notes from the PCP or Specialist.

Utilization criteria and guidelines are available upon request for the specific procedures or conditions requested.

6.6 Emergency Room Utilization, Urgent Care and Emergent Referrals

"Emergent" means a sudden injury or onset of illness that, if immediate care is not provided, may result in permanent damage or cause loss of life or limb to the patient.

If contacted by the Member, the PCP or his/her on call physician is responsible for determining the medical necessity of an urgent care or emergency room (ER) visit. After hours, urgent care referrals should be directed to the contracted urgent care centers (listed on Provider Rosters):

An acute care facility, urgent care clinic or any emergency room cannot be used to provide primary care services in lieu of the PCP's office. The PCP may refer members to an ER when an emergency or urgent condition exists. The protocols for ER referrals and care coordination are as follows:

- The PCP is responsible for immediately responding to all calls from the ER.
- The patient will receive a medical screening exam (MSE) in the ER.
- If the PCP is notified of emergent patient care, the PCP should evaluate the situation and give specific orders to ER staff.
- If the patient can be treated and released with no further treatment, the patient should be released and instructed to follow up with the PCP, not the ER.
- If the patient requires additional treatment, the ER staff must contact the PCP.
- For an inpatient admission, the ER staff should obtain an authorization from the PCP. If the PCP does not have admitting privileges at the hospital, the PCP should call the admitting physician.

Procedure for Emergent Referrals:

1. Make sure the General Referral Form contains the following information: member's name, reason for referral, member ID number, number of visits requested, specialist's name, CPT and ICD-10 codes.

2. Fax a copy of the General Referral Form to Imperial's UM department at (800) 778- 9521. Requests may also be phoned in.

3. The UM department will review eligibility, benefit coverage, and medical necessity.

4. The PCP and Specialist will receive a copy of the authorization, either by fax or electronically, within 72 hours if the authorization is approved, and within 48 hours if the authorization is denied or modified. Verbal authorizations may be given but need to be followed up in writing.

The acute care facility is responsible for notifying Imperial's UM Department via fax at (626) 283-5021 or phone at (800) 708-8273 of any ER visit or emergency inpatient admission on the business day following notification by the Member, ER, or admitting facility.

In the event the PCP is unaware of an inpatient admission, the UM department will notify the PCP upon discovery of the information.

SECTION 7. CASE MANAGEMENT PROGRAM

7.1 Case Management Referrals/Eligibility Criteria for Case Management Referrals

Imperial has established a CM program to provide a direct interface with its members and to work closely with its providers to coordinate care and services for high-risk members. CM's goal is to help members regain optimum health or improved functional capability, educate members regarding their chronic condition, and reinforce the PCP prescribed treatment plan.

Imperial utilizes two distinct processes to identify members for enrollment in CM, which include both administrative and electronic data as well as referral sources. The CM referral form is included in an appendix at the back of the Provider Manual.

7.2 Case Identification and Enrollment Criteria

CM prioritizes members based on risk and opportunity. The program aims to identify members with advanced illness (e.g., terminal illness) and chronic illness, as well as to identify opportunities to engage members in ways that will improve quality of care and outcomes while reducing avoidable costs.

General program inclusion criteria include:

- Major organ transplant;
- Major trauma;
- Poly pharmacy consisting of more than 30 prescriptions per quarter;
- Two or more admissions within a 12-month period;
- Re-admission within 30 days with the same or similar diagnosis or condition; and
- Cancer diagnosis requiring multiple treatment modalities with care coordination across multiple disciplines.

SECTION 8. HEALTH RISK ASSESSMENT

8.1 Health Risk Assessments (HRA)

At enrollment, all Special Needs Members (SNP) are given an HRA Survey in their welcome packet to fill out and return. The SNP population contains the frail elderly with certain chronic diseases who often need help managing their care. The HRA survey is designed to identify at risk members who need assistance caring for their needs, such as:

- Scheduling appointments and reminders of office visits for preventative health and specialized office visits;
- Assistance with transportation;
- Assistance with activities of daily living;
- Education and teaching of chronic diseases;
- Pain management;
- Family dynamics; and
- Coordination of care.

8.2 Individualized Care Plans for SNP (C-SNP and D-SNP)

- Care plans are generated and based upon questions and answers on the HRA survey;
- Each member is scored low, medium, or high acuity to determine the needs of each member;
- Each care plan is tailored to address identified problems, interventions, goals and any barriers to the goals;
- Bi-weekly interdisciplinary team IDT meetings are held to review the SNP member care plans;
- Care plans are sent to each member's PCP and the member for review and their records; and
- Each care plan is updated with any change of condition.

SECTION 9 NON-COVERED PROGRAM SERVICES

9.1 Non-Covered Medicare Advantage Services

The following services are not contractually covered and therefore should not be submitted for referral authorization:

- Services not received from or prescribed, referred, or authorized by Imperial (except in the case of emergency or urgent care);
- Services not specifically included in the Evidence of Coverage and Disclosure (Member Handbook) provided by the Imperial;
- Services rendered prior to the member's eligibility effective date with Imperial or following termination of coverage;
- Hospital or medical services that are not medically necessary as determined by a qualified healthcare professional;
- Cosmetic surgery (breast reconstruction is a covered benefit if following mastectomy or catastrophic disfiguring trauma);
- Experimental services;
- Infertility treatment (refer to member's EOC for limitations); and
- Unauthorized ambulance transportation for a non-emergency situation.

In any case, any questions regarding covered benefits may be forwarded to the UM department for further investigation.

9.2 Non-Covered Other Lines of Business Services

Check with each individual Plan Program's Covered Benefits and Evidence of Coverage to determine if services are covered.

SECTION 10. LINKED AND CARVED OUT MEDICARE SERVICES

Below are some of the examples of services that are linked or carved out of 'members' health plan benefits. Imperial will help coordinate these services with the provider and the appropriate public health agency.

For the Medicare Advantage Program:

- Adult ;Day Health Care Services
- Dental Services;
- Optometry Benefits; and
- Prescription Drugs – Medicare Part D.

SECTION 11. MEMBER HEALTH EDUCATION AND LANGUAGE ASSISTANCE

11.1 Advance Directives

An advance directive is a formal document, written in advance of an incapacitating illness or injury, in which one can assign decision making for future medical treatment to a third party. States legally recognize the Durable Power of Attorney for Health Care (DPAHC) as an advance directive for adults.

The responsibility of the PCP is as follows:

1. Provide all members 18 years old and above with the Patient Rights Brochure as generally outlined in Title 22, California Code of Regulations, Section 70707. A copy must be provided to the member at the initial encounter with their PCP.
2. Provide the member with the pamphlet, which addresses advance directives, surrogate decision making, and the foregoing of life sustaining procedures.
3. The PCP may assist members who have questions about an advance directive; however, the PCP may not influence the member in making the decision regarding the member's health care.
4. The PCP must document the medical record upon informing the member of the right to execute an advance directive and must document whether the member has executed an advance directive.
5. When the member executes an advance directive, a signed copy must be maintained in the medical record.
6. If the member does not have a written advance directive but expresses his/her intentions regarding future medical care, the PCP shall clearly document all communications regarding the advance directive issue in the medical record. This information must be available to alternate decision-makers for the member in the event the member subsequently becomes incapable of directing his/her own care.

11.2 Language Assistance Program

Imperial and its contracted providers are required to provide timely access to language assistance services to Limited English Proficient (LEP) members at all points of contact and at no cost to them. Language assistance services include interpreter and translation services provided by trained and competent interpreters and translators.

Providers may access telephonic interpreters for all languages by calling Imperial. Interpreter services are available 24/7. Assistance for members who are deaf, hearing, or speech impaired can be accessed telephonically through the California Relay Service. Face-to-face interpreter services are also available for Imperial members, including members who are deaf, hearing, or speech impaired, by calling Imperial. Face-to-face interpreter services must be requested 7 business days in advance.

Interpreter services at Provider Sites:

- Providers must document the member’s preferred language in the member’s medical record.
- Providers must offer interpreter services to members with LEP or who are deaf, hard of hearing, or speech impaired at no cost to the members.
    - Members are not required to provide their own interpreters or use family members or friends as interpreters. Minors should not interpret for adults. The use of family, friends, and/or minors may compromise the reliability of medical information. Use of these people could also result in a breach of confidentiality or reluctance on the part of the members to reveal personal information critical to their situations.

- Providers and staff who communicate with members in a language other than English or who act as interpreters are encouraged to take a language proficiency test by a qualified agency. At a minimum, providers and staff should document their language capabilities on a self-assessment form. The Healthcare Industry Collaborative Effort (ICE) has developed a self-assessment tool that can help bilingual providers and staff assess and document their bilingual skills. Provider or staff who report limited bilingual skills should not act as interpreters or communicate with patients in a language other than English. In this case, interpreter services should be used.
- Providers must document the request or refusal of interpreter services by an LEP or deaf, hard of hearing, or speech impaired member in the member's medical record.

Translations and Materials in Alternative Format

Members with LEP or with disabilities may request member informing and health education materials in their preferred language or in alternative formats. Alternative formats include audio, Braille and large print. Providers should forward these requests to Imperial. Imperial will use qualified translation service vendors to translate these documents to ensure accuracy and cultural and linguistic appropriateness.

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SECTION 12. COMPLAINTS AND GRIEVANCES

12.1 Member Complaints and Grievances

The complaint and grievance process applies when a member files a complaint that does not involve a determination of coverage. Grievances may be filed for issues regarding quality of care, termination, adequacy of facilities, waiting times, or interpersonal problems with providers. Please keep the following in mind:

- Members must be informed of their right to complain and may submit complaints orally or in writing to Imperial.
- Members should be directed to call Imperial's Member Services Department to file a grievance.
- Members can obtain a complaint form, either from their provider's office or Imperial's website, www.imperialhealthplan.com or www.imperialhealthholdings.com.
- Imperial is required to acknowledge a member's complaint and resolve the member's complaint within thirty (30) calendar days.
- Members can call Imperial, CMS, and/or the state HHS department if the complaint is not resolved to their satisfaction.
- Providers are expected to respond to grievance resolution requests in a timely manner, typically within two business days. Providers are expected to provide a complete response to all issues raised, including any requested records.
- Providers may not terminate members for filing a complaint.

Common reasons for grievances include:

- Length of time required to see a provide or schedule appointments;
- Difficulty in obtaining a referral;
- Lack of courteous treatment on the part of a provider's personnel;
- Crowded or cluttered waiting room conditions; and
- Member feels that the provider is not giving the member what he/she wants versus the provider determines is needed.

12.2 Provider Complaints

Providers are encouraged to aid in the overall quality improvement efforts of the provider network by bringing forth issues

that affect members' care, operational issues, or other service problems.

- Providers can submit a grievance to Imperil by telephone, fax, or letter.
- QM staff will assist in resolving the issue and will forward the complaint or problem to Imperial.
- Providers will receive written confirmation of the outcome of the grievance investigation and the QM committee's findings. Administrative and operational issues will be resolved within five (5) business days. Providers will receive written confirmation of the outcome of the grievance.

12.3 Claims Settlement & Grievance Practices

Provisions under HHS provide for fast, fair, and cost-effective dispute resolution mechanisms for claim disputes. Imperial will process claim disputes under its Provider (Claim) Dispute Resolution Policy & Procedure guidelines. Disputes must be submitted in a written format that clearly documents and identifies the issue in dispute. (Refer to the following "Downstream Provider Notice" for full disclosure and instructions). Contracted provider claim disputes should not be sent to the Appeals and Grievances department.

Claims grievances for the Medicare Advantage Program are processed under CMS regulatory guidelines and shall adhere to the timelines for receipt and response as promulgated.

12.4 Member and Provider Satisfaction Surveys

To measure the overall satisfaction of individual physicians and members, Imperial requests that providers participate in data collection regarding satisfaction.

Provider Satisfaction is recommended to be completed at least once per year.

Attached forms 14.3 and 14.4 are provided for the purpose of gaining information regarding satisfaction.

Form 14.4 is a Member Satisfaction form. Imperial requires that PCPs give these forms to members to complete. Members may complete the form and return it to the PCP or, if needed, office staff can assist the member in completion.

Form 14.3 is Provider Satisfaction Form. This form is for the PCP to complete. Both

forms should be returned to Imperial by fax at the identified number at the bottom of

the forms.

SECTION 13. COMPLIANCE

13.1 Code of Conduct and Business Ethics

The Code of Business Conduct is a critical component of a compliance plan. Imperial is committed to upholding the highest standards of integrity by following the Guiding Principles of Business Conduct, as follows:

- Be fair and responsive in serving our customers;
- Always earn and be worthy of our customers' trust;
- Respect fellow employees and reinforce the power of teamwork;
- Demonstrate a commitment to ethical and legal conduct;
- Maintain our business and compliance standards; and
- Continuously strive to improve what we do and how we do it.

13.2 Compliance Program

Imperial's Compliance Program has the potential of enhancing the quality, productivity, and efficiency of our operations while significantly reducing the probability of improper conduct and legal liability, including but not limited to reducing fraud and abuse. Imperial's Compliance Program strives to improve operational quality by fulfilling four primary goals:

- Articulate and demonstrate imperial insurance companies' commitment to regulatory compliance and legal and ethical conduct;
- Increase the likelihood of preventing, identifying, and correcting non-compliant or illegal conduct;
- Formulate and utilize internal controls to promote compliance with state and federal laws and regulations as well as organizational policies and procedures; and
- Create an environment that encourages employees to recognize and resolve potential compliance problems.

All providers, including provider employees and provider subcontractors and their employees, are required to comply with Imperial's compliance program requirements. Imperial's compliance- related training requirements include Corporate Integrity, HIPAA Privacy and Security Training and Fraud, and Waste and Abuse (FWA) Training.

13.3 Fraud, Waste and Abuse Compliance

The purpose of Imperial's Fraud and Abuse Awareness and Detection Plan is to comply with state and federal laws and regulations, to identify and reduce costs to Imperial and its providers, subscribers, payers, and enrollees caused by fraudulent activities, and to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud. Activities detailed in the anti-fraud plan include:

- Protect health care consumers and particularly Imperial members, providers, and the health plan itself against potentially fraudulent activities;
- Prevent fraudulent activity through deterrence;
- Retrospective drug utilization review of controlled substances claims for possible fraud and/or abuse by specific indicators such as multiple prescriptions, multiple prescribers, etc.;
- Detect fraud through existing mechanisms (such as claim fraud detection systems);
- Comply with the requirements of Section 1348 (a through e) of the Knox Keene Act;
- Provide a procedure for Imperial staff to follow if fraud is suspected; and
- Notify the appropriate internal departments, company officers/Board of Directors and/or government agencies.

The Fraud and Abuse Awareness and Detection Plan is made available for review in the Compliance Department and is reflected in the Fraud & Abuse Reporting System Policies and Procedures located on the Imperial's website, www.imperialhealthplan.com or www.imperialhealthholdings.com. A hard copy of these policies and procedures is available to employees and other interested parties through Imperial's administrative offices. Participating providers must follow all CMS rules and regulations. This includes the CMS requirement that all employees who work for or contract with a Medicare managed care organization meet annual compliance and education training requirements with respect to FWA. To meet federal regulation standards specific to Fraud, Waste and Abuse (§ 423.504) providers and their employees must complete an annual FWA training program.

Imperial has established a Fraud and Abuse Compliance Hotline (hereinafter "Hotline"), which is available to all employees and members 24/7. The compliance department has a system in place to receive, record, respond to, and track compliance questions or reports of suspected or detected noncompliance or potential FWA from employees, members of the governing body, enrollees, and First-Tier, Downstream and Related Entities ("FDRs) and their employees.

Employees, members, or any other interested parties may call the hotline to report suspected fraudulent, illegal, or non-compliant behavior affecting Medicare, or any other product line, at Imperial. Imperial will make every effort to maintain the confidentiality of the report and the reporting employee or other individual; however, the identity of the employee may become known or may have to be revealed during the investigation.

The hotline telephone number is (888) 708-5377. For additional compliance information, go to the plan website, www.imperialhealthplan.com and www.imperialhealthholdings.com

Members, Imperial employees, providers, or any other person who feels they may have knowledge of something suspicious

may use this hotline. This hotline will help our members, employees, providers, and purchasers feel secure that their services, money, and equipment are used appropriately. Only callers that leave their name and telephone number will receive a confirmation case number. However, if callers or those that email indicate that they wish to remain anonymous, they will not be contacted.

13.4 HIPAA Privacy Practice Notice Guidelines

A. Background

Timely, accurate, and complete health information must be collected, maintained, and made available to members of an individual's healthcare team so that members of the team can accurately diagnose and care for that individual. Most consumers understand and have no objections to this use of their information.

Although consumers trust their caregivers to maintain the privacy of their health information, they are often skeptical about the security of their information when it is placed on computers or disclosed to others. Increasingly, consumers want to be informed about what information is collected, and to have some control over how their information is used.

B. Federal Requirements

Standards for Privacy of Individually Identifiable Health Information

In general, the federal Standards for Privacy of Individually Identifiable Health Information, also known as the HIPAA Privacy Rule (45 CFR Part 160-164) requires that:

Except for certain variations or exceptions for health plans and correctional facilities, an individual has a right to notice as to the uses and disclosures of protected health information that may be made by the covered entity, as well as the individual's rights, and the covered entity's legal duties with respect to protected health information.

In general, the content of the notice must contain:

1. A header: "THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.";
2. A description, including at least one example of the types of uses and disclosures that the covered entity is permitted to make for treatment, payment, and healthcare operations;
3. A description of each of the other purposes for which the covered entity is permitted or required to use or disclose protected health information without the individual's written consent or authorization;
4. A statement that other uses and disclosures will be made only with the individual's written authorization and that the individual may revoke such authorization;
5. When applicable, separate statements that the covered entity may do the following: 1) contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual; 2) raise funds for the covered entity; and 3) that the group health plan or health insurance issuer or HMO may disclose protected health information to the sponsor of the plan;
6. A statement of the individual's rights with respect to protected health information and a brief description of how the individual may exercise these rights, including:
    - the right to request restrictions on certain uses and disclosures as provided by 45 CFR 164.522(a), including a statement that the covered entity is not required to agree to a requested restriction;
    - the right to receive confidential communications of protected health information as provided by 164.522(b), as applicable;
    - the right to inspect and copy protected health information as provided by 164.524;
    - the right to amend protected health information as provided in 164.526;
    - the right to receive an accounting of disclosures as provided in 164.528; and
    - the right to obtain a paper copy of the notice upon request as provided in 164.520;
7. A statement that the covered entity is required by law to maintain the privacy of protected health information and to provide individuals with a notice of its legal duties and privacy practices with respect to protected health information;

8. A statement that the covered entity is required to abide by the terms of the notice currently in effect;
9. A statement that the covered entity reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains;
10. A statement describing how it will provide individuals with a revised notice;
11. A statement that individuals may complain to the covered entity and to the Secretary of Health and Human Services if they believe their privacy rights have been violated; a brief description as to how one files a complaint with the covered entity; and a statement that the individual will not be retaliated against for filing a complaint;
12. The name or title and telephone number of a person or office to contact for further information; and
13. An effective date, which may not be earlier than the date on which the notice is printed or otherwise published.

Source: AHIMA Practice Brief, "Notice of Information Practices" (Updated 11/02)

SECTION 14. Quality Management Program

The mission of Imperial's QM program is to assure the delivery of quality patient care by providing and managing a coordinated, comprehensive, quality health care network in the service area, without discrimination based on health status, and in a culturally competent manner.

Imperial has not delegated QM. The QM program documents all the activities for which there is QM delegation.

Purpose

Imperial is committed to delivering high quality and affordable health care to its members. Dedicated physicians and office staff provide personal and individualized care with special sensitivity to cultural needs.

To assist the individual providers in meeting these commitments, the QM Program was developed to ensure compliance with local, state, federal, and national managed health care plan standards. Tools and guidelines provided by the health plans are incorporated to support these goals.

Scope

The scope of Imperial's QM program includes the entire spectrum of contracted providers, committee members, administrative staff, and enrolled members.

Aspects of internal administrative processes which are related to service and quality of care include credentialing, quality improvement, UM, member safety, complex case management, disease management, complaints, grievances and appeals, customer service, provider network, claims payment, and information systems.

The QM program addresses:

- Aspects of both medical care and service;
- Continuum of care issues;
- Reporting sentinel events to the health plan department, such as:
  - Admissions due to complications resulting from outpatient surgery or procedures;
  - Admissions within 48 hours after an emergency room visit;
  - Admissions within 30 days of a prior admission;
  - Admissions with a diagnosis of asthma;

- Accident, injury, and falls during a stay at an acute or skilled nursing facility;
- Decubiti;
- All deaths;
- Return to surgery as a result of a previous operation;
- Infection after invasive procedure or surgery; and
- Surgery on normal organ, body part or tissue;

- Member complaints, grievances, and appeals;
- Research and feedback from health plans;
- Provider availability and access;
  - Imperial maintains an adequate network of primary and specialty care providers and routinely monitors how effectively the network meets the needs and preferences of its membership.
  - Access and timeliness standards:
    - Regular or routine care appointment: within 15 days;
    - Urgent care appointment: within 48 hours; and
    - After-hours call by the practitioner or covering provider to the member: within 30 minutes.
    - 90% of members report that they 'always' or 'usually' get an appointment for health care at a doctor's office or clinic as soon as they need it.
    - 90% of members report that they 'always' or 'usually' get a follow-up of routine appointment as soon as they need it;
- Coordination of care and transitions of care;
- Preventative health;
- Member experience with healthcare services provided;
- Provider experience with Utilization Management; and
- Medical record audit results.

Goals and Objectives

Continually improve member experiences by measuring outcomes, and continuously improve all aspects of the healthcare continuum. This shall be accomplished through the following objectives:

- Develop and maintain an ongoing monitoring system to detect problems of quality of care or service with individuals or systems encountered by members;
- Develop, implement, and evaluate corrective action plans when deficiencies have been identified;
- Identify, implement, and assess quality improvement initiatives in the areas of quality of care, service and member safety;
- Incorporate internal and external regulatory standards related to quality improvement activities;
- Utilize results from practitioner performance issues which are obtained from a variety of sources:
  - Quality of care and service issues reported during the appeal and grievance process investigation;
  - Quality indicators, and audit/survey studies conducted throughout the year for credentialing, recredentialing, and contracting of health care providers and facilities;
- Design and maintain a QM process that supports continuous quality improvement using the cyclical methodology of planning, doing, studying, and acting;
- Preventive Health: implementing USPSTF and other evidence-based guidelines to reduce morbidity and mortality for members;

- Collaborates with health plans in the completion of health appraisals for Imperial members. This gives members the opportunity to engage actively in managing their own health care by encouraging them to complete a health risk assessment and obtain information about their health status;
- Pursue opportunities for improvement in the health status of the membership by referring them to programs that include preventative care services, health promotion, and health education;
- Pursue collaborative agreements with community-based organizations to meet the socioeconomic needs of Imperial members and improve health equity in the communities it serves;
- Use health plan data to analyze the effectiveness of the DM and other chronic disease management programs to Imperial members and implement actions if an opportunity for improvement is identified;
- Plan on re-measuring the actions taken;
- Pursue opportunities for improvement by analyzing the results of measuring member experience surveys;
- Establish clinical and service indicators that reflect the demographic characteristics of the membership population;
- Conduct Inter Rater Reviewer Reliability (IRR) on physicians and registered nurses (RNs) and licensed vocational nurses (LVNs) that make UM decisions, at least annually;
- Ensure QM activities are linked and coordinated with other services, UM, claims, credentialing, and recredentialing;
- Evaluate annually the effectiveness of the previous year's QM program, activities, and interventions; and
- Train staff with required QI activities, as needed.

Strategy

The planning and implementation of annual QM Program activities follows an established process and includes the following components.

Work Plan

Annually, the Quality Management Committee (QMC) approves a QM work plan, which details the current year program initiatives to achieve established goals and objectives, including the specific activities, methods, projected time frames for completion, and project leader for each initiative.

The scope of the work plan incorporates the needs, input, and priorities of Imperial. Work Plan initiatives are either clinical or non-clinical and address the quality and safety of clinical care and quality of service.

Initiatives include, but are not limited to, planned monitoring activities for previous initiatives, disease-specific interventions, special projects, quality improvement studies, and the annual evaluation of the QM program. The QMC oversees the prioritization and implementation of clinical and non-clinical work plan initiatives. STOP)

Quality Improvement Initiatives

Imperial's current quality improvement activities that measure and monitor access to care are as follows:

- Appointment availability studies; and
- Initial health assessment monitoring.

Imperial's current quality studies that measure and monitor provider and member experience are as follows:

- Consumer Assessment of Health Care Providers and Systems (CAHPS);
- Provider experience survey;
- Member grievance review; and
- Member experience surveys.

Imperial's current quality studies that evaluate preventive and chronic care, as well as coordination, collaboration, and patient safety, are as follows:

- Healthcare Effectiveness Data and Information Set (HEDIS);
- Coordination of care studies; and
- Patient safety studies.

Imperial's current quality studies that evaluate appropriate care for Members with complex medical needs are as follows:

- Complex case management annual evaluation; and
- Disease specific quality studies.

Imperial's current quality studies that evaluate our ability to serve a culturally and linguistically diverse membership are as follows:

- Annual provider language competency study;
- Annual cultural and linguistic study;
- Ongoing monitoring of interpreter service use; and
- Ongoing monitoring of grievances.

Measurement Process

Imperial uses quality measures to regularly monitor and evaluate the effectiveness of quality improvement initiatives and compliance with internal and external requirements. Imperial reviews and evaluates, no less than on a quarterly basis, the reports available from the health plan. IMPERIAL measures performance against community, national, or internal baselines and benchmarks when available and applicable, which are derived from peer-reviewed literature, national standards, regulatory guidelines, established clinical practice guidelines, and internal trend reviews. The findings are reported to the QMC.

Communication and Feedback

Ongoing education and communication regarding quality improvement initiatives is accomplished internally and externally through committees, staff meetings, mailings, and announcements. Imperial implements the following:

- Providers are educated regarding quality improvement initiatives through on-site quality visits, provider newsletters, specific mailings, and Imperial's website ;
- Specific performance feedback regarding actions or data is communicated to providers;
- General and measure-specific performance feedbacks are shared via special mailings, provider newsletter, and Imperial's website;
-
    - Discussions regarding the results of medical chart audits, grievances, appeals, referral patterns, utilization patterns, and compliance with contractual requirements;
    - Performance indicators are also used to identify quality issues. When identified, Imperial's QM staff investigates cases and determines the appropriate corrective action plans (CAP). IMPERIAL subcommittees review cases involving patient safety and quality of care issues and recommend actions to the QMC;
    - Providers or practitioners that are significantly out of compliance with QM requirements must submit a CAP. Persistent non-compliance, or failure to adequately address or explain discrepancies identified through oversight activities, may result in freezing of new Member enrollment; a requirement to subcontract out the deficient activities within the MSO or Independent Physician Association (IPA); de-delegation of specified functions; or termination of participation or non-renewal of the agreement with IIC.

Annual Evaluation and Update of the QM Program

Imperial's QM Staff, including the Chief Medical Officer, evaluates and reviews the effectiveness and progress of the QM Program and Work Plan on an annual basis and provides updates as needed. A yearly summary of all completed and ongoing QM program activities addresses quality and safety of clinical care and quality of service. The evaluation documents evidence of improved health care or deficiencies, progress in improving safe clinical practices, status of studies initiated or completed, timelines, and methodologies used.

- The report includes pertinent results from QM Program studies, patient access to care, Imperial's standards, physician credentialing and facility review compliance, member experience, evidence of the overall effectiveness of the program, and significant activities affecting medical and behavioral health care provided to members. Performance measures are trended over time and compared with established performance thresholds to determine service, safe clinical practices, and clinical care issues, with analysis of results, including barrier analysis, to verify improvements. The CMO presents the results to the QMC for comments, consideration of performance, suggested program adjustments, and revision of procedures or guidelines as necessary. Also included is a work plan for the coming year. The work plan includes studies, surveys, and audits to be performed, compliance submissions, reports to be generated, and quality activities projected for completion.

Monitoring Activities

Imperial p e r f o r m s a series of activities to monitor the IPA and other delegated entities.

For Imperial's management, and **when there is delegation,** the following activities take place:

Annual Delegation Oversight Audit using a designated audit tool:

- Joint operations meetings;
- Review of grievances and other quality information;
- Specified audits;
- Focused approved and denied referral audits;
- Focused case management audits;
- Focused practitioner audits for clinical care;
- Facility and medical record reviews;
- Utilization data review; and
- Provider satisfaction surveys.

Enforcement and Compliance

The QMC is responsible for monitoring and oversight of the QM Program, including enforcement of compliance with Imperial standards and required activities.

In general, to obtain compliance when deficiencies are noted, CAPs are requested and followed up on.

Authority and Responsibilities

Board of Directors

Through the QMC, the Board of Directors (Board) has the ultimate responsibility and authority for the quality of care and

service delivered by member providers. The Board reviews and approves the QM program and the QM work plan on an annual basis.

Chief Executive Officer

Imperial's Chief Executive Officer (CEO) has organizational responsibility for the QM program and ensures adequate resources and qualified staffing in order to execute the QM functions. The CEO reports to the Board.

Senior Medical Director

The Senior Medical Director (SMD) for Imperial is responsible for the daily oversight of QM activities. The SMD reports to Imperial's CEO.

QMC Structure

The QMC reports directly to the Board. The QMC has primary responsibility for overseeing implementation of the QM program and the QM annual work plan. The QMC recommends policy decisions, reviews and evaluates the results of QM activities, recommends corrective action plans, and ensures implemented plans are effective.

The QMC is interdisciplinary, with membership appointed by the Board in accordance with the bylaws. Operation of the QMC is by simple majority. No committee member shall vote on any case in which he/she is personally involved. An Imperial physician appointed by the Board chairs the QMC. There are three voting members in the QMC, which include network physicians from Primary Care, as well as specialty physicians. A quorum is achieved with two member Physicians present.

Active participation on the QMC includes consistent meeting attendance, involvement in discussions of agenda items, analyzing results, and assisting in follow-up and problem resolution.

QMC members are appointed annually to assure broad representation and may be reappointed at the discretion of the Board.

Imperial's non-physician employees are non-voting participants.

Imperial's Medical Director or their designees may attend meetings with prior notification and sign a confidentiality statement. The QMC is scheduled to meet quarterly.

Issues that arise prior to a scheduled meeting which require immediate action will be taken directly to Imperial's CMO for review, who may refer the issue to the Medical Director or call an ad hoc QMC quorum.

QMC Subcommittees

The following Subcommittees, chaired by Imperial's Senior Medical Director or designee, report findings and recommendations to the QMC. The subcommittees meet at least quarterly, and more frequently if necessary.

Peer Review

The Peer Review (PR) subcommittee is responsible for PR activities for Imperial.

Structure

The PR subcommittee is composed of Imperial's medical directors or designated physicians' representative of network practitioners. A behavioral health practitioner and any other specialist, not represented by committee members, serve on an ad hoc basis for related issues.

Function

The PR subcommittee serves as the committee for clinical quality review of practitioners, evaluates and makes decisions

regarding member or provider grievances as well as clinical quality of care cases referred by the health plans.

Credentialing

The credentialing subcommittee performs credentialing functions for providers who either directly contract with Imperial or for those submitted for approval of participation in Imperial's network by IPAs that have not been delegated credentialing responsibilities.

Role

The credentialing subcommittee is responsible for reviewing individual providers who contract directly with Imperial. This subcommittee denies or approves their participation in Imperial's network.

Structure

The credentialing subcommittee is composed of multidisciplinary participating PCPs or specialist's representative of network practitioners. A behavioral health practitioner and any other specialist not represented by committee members may serve on an ad hoc basis for related issues.

Function

The credentialing subcommittee provides thoughtful discussion and consideration of all network practitioners being credentialed or re-credentialed. The subcommittee also reviews practitioner qualifications, including adverse findings, and approves or denies continued participation in the network.

If delegated for facility site review, Imperial completes a site review as part of its initial credentialing process when adding a new provider to its provider network who works at a site the organization has not previously reviewed.

The recredentialing review takes place every three (3) years. IMPERIAL ensures that decisions are non- discriminatory.

Pharmacy and Therapeutics (P&T)

The P&T subcommittee performs ongoing review and modification of Imperial's formulary and related processes as well as oversight of the pharmacy network, including medication prescribing practices by Imperial's providers.

The P&T subcommittee assesses usage patterns by members and assists with study design, clinical guidelines, and other related functions. The subcommittee is responsible for reviewing and updating clinical practice guidelines that are primarily medication related.

Role

The P&T subcommittee is responsible for maintaining a current and effective formulary, monitoring medication prescribing practices by Imperial practitioners, and under and over-utilization of medications.

Structure

The P&T subcommittee is composed of clinical pharmacists and designated physician's representative of the network providers. A behavioral health practitioner and any other specialist not represented by committee members may serve on an ad hoc basis for related issues.

Function

The P&T subcommittee serves to objectively appraise, evaluate, and select pharmaceutical products for formulary inclusion and exclusion. The subcommittee provides recommendations regarding protocols and procedures for pharmaceutical management and the use of non-formulary medications on an ongoing basis. The subcommittee also ensures that decisions

are based only on appropriateness of care and services. The P&T subcommittee is responsible for developing, reviewing, recommending, and directing the distribution of disease state management or treatment guidelines for specific diseases or conditions that are primarily medication related.

Utilization Management (UM)

The medical services committee (MSC) performs oversight of UM activities conducted by to maintain high quality health care as well as effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services.

Role

The MSC directs the continuous monitoring of all aspects of UM and CM administered to members.

Structure

The MSC is composed of Imperial medical directors, or designated physicians representative of network practitioners. A behavioral health physician and any other specialist not represented by committee members may serve on an ad hoc basis for related issues.

Function

The MSC reviews and approves UM and CM policies and procedures annually. The committee monitors for over and under-utilization and ensures that UM decisions are based only on appropriateness of care and service. Additionally, the MSC annually reviews the UM program, policies and procedures, work plan, and evaluation.

The QMC reviews and updates preventive care and clinical practice guidelines that are not primarily medication related.

QMC Responsibilities

- Annually review, modify, and approve:
  - Evaluation of Previous Year QM Program;
  - QM Program;
  - QM Workplan; and
  - QM Policies& Procedures;
- Review and acceptance of:
  - Preventive health guidelines received from Health Plans;
- Ongoing review of:
  - Health Plan reports;
  - Standards for over and under utilization;
- Identify opportunities to improve care; Ensure integration of QM and UM activities;
- Analyze the results of QM activities to determine if there are opportunities for improvement;
- Ensure overall program effectiveness by evaluating the administration of the program throughout all service areas;
- Review potential quality of care and quality of service issues referred from the UM committee and credentialing committee;
  - Forwards identified issues to the specific health plan;
    - Evaluates and approves reports sent to the Board;
- Review the results of annual health plan audits and evaluates any need for actions that arise from the results;

- Ensures that the information and findings of studies, surveys, and audits are used to detect trends, patterns of performance, or potential problems, and that CAPs are implemented. It also ensures that necessary information is communicated to the relevant providers, departments, or institutions when problems or opportunities to improve care and/or service are identified;
- Identifies findings appropriate for inclusion in provider quality files that are reviewed at the time of recredentialing. The committee may choose to send information to the credentialing committee prior to reappointment, according to its discretion.

QMC Confidentiality Statement

All members of the QMC shall be required to sign a confidentiality statement at least annually. The confidentiality agreement will be kept on file at Imperial's offices. All QMC records and proceedings are confidential and protected as provided by the state's Evidence Code, whether marked: "Confidential and protected as defined by state Evidence Code." Signed minutes are maintained in a locked file at IMPERIAL offices, available only to authorized persons.

Committee Minutes

QMC minutes and documents may be reviewed by authorized Imperial representatives.

However, no copies will be provided, and confidentiality of the information will be preserved.

The QMC implements the following practices:

- A standardized agenda and minutes format is used for all meetings. Minutes are taken during the meeting to reflect all committee activities, decisions, and actions. Approved agendas and minutes are kept in a confidential manner at Imperial offices;
- A copy of the approved minutes is forwarded to the following Board meeting;
- Minutes shall include—but are not limited to—the following subjects;
- Discussion of QM program issues;
- Practitioner behavior;
- Selection of important aspects of care and performance measures to monitor and evaluate;
- Analyses of results of member and provider experience surveys; and
- Analyses of health plan reports addressing accessibility, availability, and medical record audits.

To ensure follow-up on all agenda items, issues are carried on the agenda until resolved. The finalized minutes are reviewed by the committee chairperson and are submitted to the QMC for approval at the next scheduled meeting. Minutes will reflect review, changes if necessary, and approval by the committee.

Clinical Practice Guidelines

Imperial is committed to improving health with optimal outcomes. Clinical practice and preventive health guidelines assist physicians by providing a summary of evidence-based recommendations for the evaluation and treatment of preventive aspects and select common acute and chronic conditions.

Imperial's clinical practice guidelines focus on important aspects of care with recognized, evidence-based, and measurable best practices for high-volume diagnoses. The basis of the guidelines includes a variety of sources that are nationally recognized, evidence-based, or are expert consensus documents. Additional points have been included where medical literature and expert opinion are noted. Network physician involvement is a crucial part of the guideline development as well as adoption for the organization after approval by Imperial's QMC and MSC.

If you have any questions regarding the clinical practice guidelines, contact the Quality Department.

Quality Management (QM) and Improvement (QI) Delegation Oversight:

Imperial provides oversight, consultative, and educational services for all delegated entities.

Pre-Delegation Assessment / Evaluation

Imperial conducts pre-delegation evaluation prior to implementing delegation.

Delegation Agreement

When there is QI sub-delegation, a delegation agreement (Agreement) is executed outlining the responsibilities and activities of the delegated entity that is delegated to provide QM services. The Agreement includes the following:

- Specific QI activities performed by the delegate, in detailed language;
- Specific QI functions that are not delegated and will be retained internally;
- The use of protected health information (PHI) by the delegated entity, with the following provisions:
  - A list of the allowed used of PHI;
  - Specifics regarding the use and disclosure of PHI;
  - A description of safeguards to protect the information from inappropriate use or further disclosure;
  - A stipulation that the delegate ensure that sub-delegates have similar safeguards to provide reasonable administrative, technical, and physical safeguards to ensure PHI confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use or disclosure of PHI;
  - A stipulation that the delegate provides individuals with access of their PHI;
  - That the delegate ensures that PHI will be secured through basic protections or physical facilities that store PHI in any form. It will also ensure that electronic systems are protected from unauthorized access and internal and external data tampering.

Communication to Imperial's Providers & Delegates

Imperial provides the following information to the network provider and its delegated entities:

- Member experience data, if delegated by Imperial or contracted health plan;
- Data from:
  - Complaints;
  - CAHPS 5.0 H Survey results;
  - Other data collected on members' experience with the delegate's services; and
  - Clinical performance data.
- HEDIS measures, claims, and other clinical data collected by the organization or its contracted health plan, if applicable.

Provider Contracting

Imperial's contracts with providers specifically require and/or include the following:

- Providers cooperate with QI activities;
- Providers maintain the confidentiality of member information and records;
- Providers allow the organization to use their performance data for quality improvement activities;
- An affirmative statement indicating providers may freely communicate with patients about their treatment, regardless of benefit coverage limitations;
- Provider manual or policies are considered extensions of the contract.

Imperial's contracting staff conducts periodic medical record audits, and at least an evaluation every two (2) years for contracted providers with more than fifty (50) members, to determine compliance with medical record standards and achievement of performance goals.

Audit results with deficiencies found will be reported to the QMC, credentialing committee, and the practitioner. The following are the recommended thresholds and actions required:

Continuity and Coordination of Care & Transitions of Care

Imperial takes an active role in facilitating patient care across transitions and settings. Imperial's policies and procedures support providers in continuity and coordination of care across settings or transitions between medical and behavioral health services and between practitioners and providers.

The policies and procedures include medical and behavioral health care with the focus on:

- Members getting the care they need; and
- Providers getting the information they need to provide the care members need.
- Member Safety

Imperial continuously monitors patient safety to support providers in improving the safety of their practices.

- PCP Offices
  This study assesses PCP compliance with Imperial and state HHS standards for patient safety and identifies common areas of deficiency in physical facility accommodations and infection control practices throughout Imperial's network.

- Inpatient Facilities
  Imperial considers the quality of care in acute, rehabilitation, and skilled nursing facilities to be a top priority. To ensure member safety, Imperial assesses, tracks, and reviews the following measures:
  - Readmission reports;
  - One day length of stay reports;
  - Post-op wound infection referrals;

- Quality of Care referrals for any adverse outcome related to an inpatient stay.

QM Activities

- Standing annual activities included in the QM program are as follows:
  - Review of health plan audits related to:
    - Access audits (e.g., a member's ability to receive an appointment with a provider within a specified time frame, depending on the type of appointment);
    - Availability audits (e.g., a member's ability to contact a provider according to protocols); and
    - Office waiting time audits (e.g., members not waiting more than
  - 30 minutes on average, per provider, for their scheduled appointments);
- Review of member experience survey results and development of CAPS if indicated;
- Review of provider experience surveys and development of CAPS if indicated;
- Clinical practice guidelines development and adoption; and
  - Ongoing quality of care and case reviews per policy and procedure.

QM Annual Work Plan

- The QM annual work plan is developed and implemented to assist in achieving the above goals in a manner that is organized, systematic, and ongoing. The basic method of planning, doing, studying the results, and implementing needed improvements is the approach that best supports QM and quality improvement activities.
- The QM annual work plan will include the following elements in its structure:
  - Measurable objectives for all projects and activities;
  - Name of person accountable for each activity;
  - Time frame for completion for each activity;
  - Monitoring of previously identified changes, issues, and corrective actions;
  - Scheduled date for program project and activity re-evaluation.

Coordination of UM and QM Functions

- The UM program, the MSC, with its emphasis on medical service utilization management, and the QM program, which focuses on the concepts of QM and continuous quality improvement, work in conjunction with one another. Imperial has created linkages between the two programs through committee structures and processes.

- Potential quality issues are identified by all departments and committees. The UM department and the QMC use the established referral process of case management and concurrent review to refer any sentinel events and potential quality issues for review by the QMC. Similarly, any potential UM issues identified by the QMC are referred to the UM Department and MSC for review. The issues are investigated and reviewed by the respective departments and committees when corrective actions may be recommended. The UM and QMC provide an environment to ensure that each program is functioning in concert with the other.

QM Process

The QM process includes ongoing evaluation of the overall effectiveness of the QM Program. Actions are taken to implement the appropriate changes that demonstrate improvement in the quality of clinical care or service to members and providers. The process is implemented on a continuous basis with re-evaluation and subsequent corrective actions addressed. Elements of this process include the following:

Identification:	Select an area for potential improvement.
Measure:	Audit findings, internal and external experience reports, other survey findings, etc.
Act:	Implement corrective actions or improvement activities.
Reassess:	Re-measure to identify the effectiveness of the improvement activities.

The **QM process** is integrated across all departments. Key indicators of clinical and service quality that reflect the needs of members, providers, and health plans have been developed. Standards, goals, guidelines, or benchmarks will be defined for each indicator. Action plans are implemented and monitored to address those areas that fall below the indicated standards.

Annual QM Program Evaluation

The QMC provides an annual evaluation of the effectiveness of the QM program and work plan activities to the Board. The report includes:

- Progress made on achieving goals of the program;
- Summary and trending of monitoring and evaluation activities;
- Special studies and reports;
- Follow-up actions taken on previous studies and reports;
- Effectiveness of those actions and demonstrated improvement in the quality of care and service provided;
- Descriptions of how the network has changed as a result of QM activities;
- Suggestions for activities to be included in the program; and
- Recommendations on future QM activities, work plan revisions, and changes to the overall Program. The Board may approve the recommendations and report or may make independent recommendations.
-

SECTION 15. PROVIDER AND HOSPITAL ROSTER

15.1 Laboratory

Quest Diagnostics (Please see Patient Service Centers Roster)
8401 Fallbrook Ave.
West Hills, CA 91304
866-MYQUEST (1-866-697-8378)
www.QuestDiagnostics.com

15.2 Radiology/Diagnostic Centers

Refer to the list of contracted providers sent to you by Imperial.

15.3 Contracted Hospital Facilities

Imperial uses contracted hospital and inpatient facilities (skilled nursing, rehab, etc.). Imperial will periodically send the list of contracted hospitals and facilities for the health plan to PCPs. If the PCP has an immediate need to know the contracted hospitals and facilities, please contact the UM department, look on Imperial's website, or contact an Imperial provider services representative.

15.4 PCP and SPECIALIST ROSTER

Refer to the list of contracted providers sent to you by Imperial.

SECTION 16. CLAIMS

Overview:
The focus of Imperial's claims department is to ensure claims are processed timely and accurately and in accordance with state and federal regulations. Imperial has established a toll-free telephone number for providers to access a representative in the customer service department. Providers may call (626) 708-0333 and select option 3 for claims.

Timely Claims Submission:
Clean claims for Medicare members are completed within 30-calendar days and 60-calendar days for contracted providers unless otherwise noted in the provider agreement. For non-clean claims, the provider will receive a written request identifying Imperial's claim number, the date the claim was received, the patient's first and last name, the patient ID, the date of service, and an explanation as to the information required to adjudicate the claim. If the requested information is not received, the claim will be closed, and the provider will receive an Explanation of Payment (EOP) with a detailed explanation as to the reason why the claim was denied.

A "clean claim" is defined as a claim for a covered service that has no defect or impropriety and otherwise conforms to the clean claim requirements for equivalent claims under original Medicare. A defect or impropriety includes, without limitation, lack of data fields required by Imperial or substantiating documentation, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim. If additional substantiating documentation involves a source outside of IIC, the claim is not considered clean.

Submission of Claims:
As an Imperial participating provider, you have agreed to submit all claims within the timeframes outlined in your agreement.

While Imperial prefers claims to be submitted electronically, both electronic and paper claims are accepted. Claims must be sent to the following:

Imperial Health Plan of California	Via Mail:	P.O. Box 60874 Pasadena, CA 91116-6874
	Via Clearinghouse: Office Ally Payer Code: IHP01	
Imperial Health Holdings Medical Group	Via Mail:	P.O. Box 60075 Pasadena, CA. 91116-6874
	Via Clearinghouse: Office Ally Payer Code: IHHMG	

Tax ID and National Provider Identifier Requirements
Imperial requires the payer-issued Tax Identification Number (TIN) and National Provider Identifier (NPI) on all claim's submissions.

Imperial will reject claims without the TIN and NPI, and such claims will not qualify as Clean Claims. More information on NPI requirements, including HIPAA's NPI Final Rule Administrative Simplification, is available on the CMS website at www.cms.gov/Regulations-and- Guidance/HIPPA-AdministrativeSimplification/NationalProvidentStand.

National Drug Codes
Imperial follows CMS guidelines regarding National Drug Codes (NDCs). Providers must submit NDCs as required by CMS.

Claim Format:
The standard CMS required forms and data elements can be found in the CMS claims processing manual located at https://www.cms.gov/manuals/downloads/clm104c12.pdf. Appropriate forms and data elements must be present for a claim to be considered a clean claim.

Documentation
Imperial reserves the right to request documentation of utilization for any claim, even when that claim has a corresponding valid authorization. In these cases, Imperial requests medical records for utilizations with a valid authorization in order to ensure medical necessity and the accuracy of billing. The utilization is authorized, but we need to validate the individual diagnoses and services.

Billing and balance billing members
You may bill or charge Imperial members for applicable copayments, coinsurance and/or deductibles. Your provider agreement addresses the circumstances under which you can bill Imperial members. However, Imperial wants to protect our members from unnecessary or inappropriate billing.
Therefore, you may not balance bill members when claims are denied for administrative reasons, such as lack of referral or authorization when one is required.

Other billing situations:
Billing an Imperial member who has exhausted their benefits: When a member has exhausted their benefits, you cannot charge them more than the contracted rate if you continue to see them. For example, if a plan covers 10 visits but you provide 12, you cannot bill the member more than the contracted rate for the two additional visits. As noted above, you are also required to notify the member that their insurance does not cover the two additional visits and obtain the member's prior written consent to pay for the two additional visits.

Billing members for services denied by Imperial: Imperial may adjust or deny payment of covered services upon UM review. You cannot bill a member for a service that we denied because of our UM review. If your bill for a covered service is adjusted because of a UM or bill review, you cannot balance bill the member for the amount that Imperial does not pay. An example of this would be if a member is approved to stay in a hospital for eight days but the hospital does not release them for ten days. In this situation, Imperial will not cover the two additional days, but the hospital cannot bill the member for the two additional days.

Claims Overpayments:
If determines that it has overpaid a claim, Imperial will notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date(s) of service, and a clear explanation of the basis upon which Imperial believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

If the provider contests Imperial's notice of overpayment of a claim, the provider, within 30 working days of the receipt of the notice of overpayment of a claim, must send written notice to Imperial stating the basis upon which the provider believes the claim was not overpaid. Imperial will process the contested notice in accordance with Imperial's contracted provider dispute resolution process described in Section 16.2 above.

If the provider does not contest Imperial's notice of overpayment of a claim, the provider must reimburse Imperial within thirty (30) working days of the provider's receipt of the notice of overpayment of a claim.

Imperial may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when: (1) the provider fails to reimburse Imperial within the timeframe set forth in Section 16.2.B. above; and/or (2) Imperial's contract with the provider specifically authorizes Imperial to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, Imperial will provide a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim(s).

Coordination of Benefits

Imperial shall coordinate payment for covered services in accordance with the terms of a member's benefit plan, applicable state and federal laws, and applicable CMS guidance. If Imperial is the secondary insurer, providers shall bill primary insurers for items and services they provide to a member before they submit claims for the same items or services to. Any balance due after receipt of payment from the primary payer should be submitted to Imperial for consideration, and the claim must include information verifying the payment amount received from the primary payer. Provider will need to send a copy of the primary insurer's explanation of benefits.

Imperial may recoup payments for items or services provided to a member where other insurers are determined to be responsible for such items and services, to the extent permitted by applicable laws.

Members under the Medicare Advantage line of business may be covered under more than one insurance policy at a time. In the event that Imperial has information on file to suggest the member has other insurance primary to Imperial, Imperial may deny the claim. If the primary insurance has terminated, the provider is responsible for submitting the initial claim with proof that coverage was terminated. If primary insurance has retroactively terminated, the provider is responsible for submitting the initial claim with proof that payment has been returned to the primary insurance carrier.

When benefits are coordinated with another insurance carrier as primary and the payment amount is equal to or exceeds Imperial's liability, no additional payment will be made.

Claims Payment Disputes:
The claims payment dispute process addresses claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc. Claim payment disputes must be submitted to Imperial in writing within 90 calendar days of the date of denial set forth in the EOP.

- When submitting a dispute, the provider must provide the following information: •
- Date(s) of service;
- Member name;
- Member ID number and/or date of birth;
- Provider name;
- Provider TIN;
- Total billed charges;
- Provider's statement explaining the reason for the dispute; and
- Supporting documentation when necessary (e.g., proof of timely filing, medical records).

Contracted providers must use the provider dispute resolution form and mail it to the address on the form. Requests and form should not be sent to the appeals department.

Reimbursement
Imperial applies the CMS site-of-service payment differentials in its fee schedules for CPT-4 codes based on the place of treatment (physician office services versus other places of treatment).

Surgical Payments
Reimbursement to a surgeon for surgical services includes charges for preoperative evaluation and care, surgical procedures, and postoperative care.
The following claims payment policies apply to surgical services:

• Incidental Surgeries/Complications: A procedure that was performed incidental to the primary surgery will be considered as part of the primary surgery charges and will not be eligible for extra payment. Any complicated procedure that warrants consideration for extra payment should be identified with an operative report and the appropriate modifier. A determination will be made by Imperial's medical director regarding whether the proposed complication merits additional compensation above the usual allowable amount.

• Admission Examination: One charge for an admission history and physical from either the surgeon or the physician will be eligible for payment, which should be coded and billed separately.

- Follow-up Surgery Charges: Charges for follow-up surgery visits are considered to be included in the surgical service charge, and providers should not submit a claim for such visits. Providers are not compensated separately. Follow-up days included in the global surgical period vary by procedure and are based on CMS policy.

- Multiple Procedures: Payment for multiple procedures is based on current CMS percentages methodologies. The percentages apply when eligible multiple surgical procedures are performed under one continuous medical service, or when multiple surgical procedures are performed on the same day and by the same surgeon.

- Assistant Surgeon: Payment for an assistant surgeon and/or a non-physician practitioner for assistant surgery is based on current CMS percentages methodologies.

- Co-Surgeon: Payment for a co-surgeon is based on current CMS percentages methodologies. In these cases, each surgeon should report his or her distinct, operative work by adding the appropriate modifier to the procedure code and any associated add on code(s) for that procedure if both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the modifier "62" added.

Modifiers
Imperial follows CMS guidelines regarding modifiers and only reimburses modifiers reimbursed by CMS. Pricing modifier(s) should be placed in the first position(s) of the claim form.

Virtual Examiner
Under CMS guidelines, compliance programs are a necessity in today's healthcare arena. With that in mind, Imperial has implemented a software solution which provides increased regulatory oversight in accordance with CMS.

A key regulatory mandate was the implementation of the Correct Coding Initiative edits into claims processing for all Medicaid and Medicare Managed Care Plans. One of the goals of Imperial's compliance program is to focus on areas under government inspection and review. When investigating fraud and abuse, federal and state agents are looking at the following

areas: unbundling, up-coding, medically unnecessary services, duplicate billing, and billing for services not rendered.

Imperial utilizes the *Virtual Examiner*® as a technologically advanced tool for highlighting aberrant billing policies and procedures. Using nationally recognized payment and coding guidelines, *Virtual Examiner*® allows the claims examiner to pend, edit, or deny claim entries.

SECTION 17. OFFICE ALLY & ONLINE SERVICES

Web Portal, Imperial Health Plan of California and Imperial Health Holdings, Website

Please visit our website to verify eligibility, submit claims, authorization submission, and inquiry status information. Providers can also take advantage of our online service to download a copy of the PCP and specialist provider rosters. You can also search individually for a PCP, specialist, and ancillary provider.

Our on-line features include:

- Authorization status inquiry;
- Authorization submission;
- Claims status;
- Provider rosters;
- Provider search inquiries; and
- Member eligibility verification.

To set up an account with Imperial's web portal, contact us by phone at (626) 838-5100, extension 7 (portal assistance).

Office Ally providers are encouraged to set up an account to start submitting all claims through Office Ally. Imperial has opted to partner with Office Ally for all claims submissions.

Please note our payer ID's:

Imperial Health Plan of CA is: IHP01

Imperial Health Holdings Medical Group: IHHMG

To set up an account with Office Ally, please contact them directly at (866) 575-4120 or email them at OfficeAlly.com.

SECTION 18. PATIENT'S RIGHTS AND RESPONSIBILITIES

It is the Patient's Rights to:

1. A reasonable response to the patient's requests and needs for treatment or service, within the hospital's capacity, its stated mission, and applicable law and regulation;

2. Considerate and respectful care, as follows:

a. the care of the patient includes consideration of the psychosocial, spiritual, and cultural variables that influence the perceptions of illness;

b. the care of the dying patient optimizes the comfort and dignity of the patient through:

(i) treating primary and secondary symptoms that respond to treatment as desired by the patient or surrogate decision maker;

(ii) effectively managing pain; and

(iii) acknowledging the psychosocial and spiritual concerns of the patient and the family regarding dying and the expression of grief by the patient and family;

3. Make decisions involving his or her health care, in collaboration with his or her physician, to include the following:

a. the right of the patient to accept medical care or to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of such refusal; and

b. the right of the patient to formulate advance directives and to appoint a surrogate to make health care decisions on his or her behalf to the extent permitted by law. Advance directives are written instructions recognized under state law relating to the provision of health care when individuals are unable to communicate their wishes regarding medical treatment. The advance directive may be a written document authorizing an agent or surrogate to make decisions on an individual's behalf (a medical power of attorney for health care), a written or verbal statement (a living will), or some other form of instruction recognized under state law specifically addressing the provisions of health care;

(i) a hospital shall have in place a mechanism to ascertain the existence of, and, as appropriate, assist in the development of advance directives at the time of the patient's admission;

(ii) the provision of care shall not be conditioned on the existence of an advance directive; and

(iii) an advance directive(s) shall be in the patient's medical record and shall be reviewed periodically with the patient or surrogate decision maker if the patient has executed an advance directive;

4. Access information necessary to enable him or her to make treatment decisions that reflect his or her wishes; a policy on informed decision making shall be adopted, implemented, and enforced by the medical staff and governing body and shall be consistent with any legal requirements;

5. Receipt, at the time of admission, of information about the hospital's patient rights policy(ies) and the mechanism for the initiation, review, and when possible, resolution of patient complaints concerning the quality of care;

6. Participation in the consideration of ethical issues that arise in the care of the patient. The hospital shall have a mechanism for the consideration of ethical issues arising in the care of patients and to provide education to care givers and patients on ethical issues in health care;

7. Be informed of any human experimentation or other research or educational projects affecting his or her care or treatment;

8. To personal privacy and confidentiality of information;

9. Access information contained in the patient's medical record, within the limits of the law; and

10. the right of the patient's guardian, next of kin, or legally authorized responsible person to exercise, to the extent permitted by law, the rights delineated on behalf of the patient if the patient:

a. has been adjudicated incompetent in accordance with the law;

b. is found by his or her physician to be medically incapable of understanding the proposed treatment or procedure;

c. is unable to communicate his or her wishes regarding treatment; or

d. is a minor;

11. Follow the plans and instruction for care agreed upon with his/her practitioners;

12. Provide, to the extent possible, information that the medical group and its practitioners and providers need in order to care for the patient;

13. Contact his/her physician or health plan with any questions or concerns about health benefits or health care services;

14. Understand health benefits; follow proper procedures to obtain services, and to abide by health plan rules.

SECTION 19. FORMS & APPENDICES

19.1 IHCA Direct Referral Form

19.2 IHHMG Direct Referral Form

19.3 Case Management Referral Form

19.4 EZ-Net Portal Application

19.5 EZ-Net Portal Guide

19.6 Provider Satisfaction Survey Enclosed

19.7 Member Satisfaction Survey (only available if disseminated by health plan) Enclosed

19.8 Gap Report Cover Letter

19.9 HEDIS Guide

19.10 Key Contact List

19.11 IHCA Pre-Certification Referral Form

19.12 IHHMG Pre-Certification Referral Form

IMPERIAL HEALTH PLAN OF CALIFORNIA

PRECERTIFICATION/REFERRAL REQUEST FORM

Fax request to (214) 452-1905 or to check referral status, please call 1 (800) 708-8273

Date Submitted _____

☐ **STANDARD** ☐ **URGENT**

Referring Provider_____**Phone #**_____**Fax #** _____

☐ **OFFICE** ☐ **AMBULATORY SURGICAL CENTER** ☐ **OUTPATIENT HOSPITAL** **REQUESTED DATE OFSERVICE** _____

☐ **HOME** ☐ **DME** ☐ **INPATIENT/ACUTE** ☐ **REHAB/ LTAC** ☐ **SNF** **SCHEDULED ADMIT DATE** _____

Member Name (full name)_____**Date of Birth** _____

Member ID#_____ ☐ **Other Insurance/Worker'sComp**_____

PCP Name_____**PCP Phone #**

_____

Requested Services

CPT/HCPCS Code_____**Qty**_____☐ **units** ☐ **visits** **Procedure description** _____

CPT/HCPCS Code_____**Qty**_____☐ **units** ☐ **visits** **Procedure description** _____

CPT/HCPCS Code_____**Qty**_____☐ **units** ☐ **visits** **Procedure description** _____

CPT/HCPCS Code_____**Qty**_____☐ **units** ☐ **visits** **Procedure description** _____

Diagnosis

ICD code_____**Dx description**_____**ICD code**_____**Dx description**_____

ICD code_____**Dx description**_____**ICD code**_____**Dx description**_____

Requested Specialist/Provider

Name_____**Specialty** _____

Phone #_____**Fax #** _____

Tax ID#_____**NPI #** _____

Requested Facility

Facility Name_____ **Phone #** _____

Tax ID#_____ **NPI #**

Please Attach Clinicals/Therapy/Prescription/Imaging to support Medical Necessity. Only completed referrals will be processed. Do not combine multiple requests for different specialties in a single fax. This referral is valid only for services authorized on this form. This Referral Form does not guarantee payment by Imperial Insurance Companies. Responsibility for payment shall be subject to member eligibility, benefit limitations, and the interpretation of benefits under applicable subrogation and coordination of benefits rules. As the Primary Care Physician (PCP), I am referring this patient to you for the above treatment. For any other services it will be necessary to obtain an additional referral authorization.

_____

IMPERIAL HEALTH PLAN OF CALIFORNIA

Direct Access Referral Form

Complete all sections of the form and give original to the member. No additional authorization is needed. Retain copy in patient records.

Member Information

Full Name_____ **Date of Birth**_____ **Gender** ☐ **M** ☐ **F**

Phone Number_____ **Health Plan**_____ **Member ID#**_____

PCP Name_____ **PCP Phone #**_____ **PCP Fax #**_____

Diagnosis

ICD code_____ **Dx description**_____ **ICD code**_____ **Dx description**_____

Requested Specialist/Provider

Name_____ **Specialty** _____

Address_____ **City**_____ **State**_____ **Zip Code** _____

Phone #_____ **Fax #** _____

QTY	OUTPATIENT VISITS (Including Behavioral Health)	
1	99201 - 99204	New Patient Consults
	99211 – 99214	Established Patient Follow-Up **(Up to 3 Visits)**
QTY	**PHYSICAL THERAPY**	
	MCR - 9 series MCL - X codes	Physical Therapy Evaluation and 2 treatment visits
QTY	**X-RAYS**	
	73560 - 73660	Lower Leg, Ankle & Foot
	73090 - 73140	Forearm & Hand
	73030 - 73085	Shoulder & Upper Arm
	73501 - 73552	Pelvic Region & Thigh
	71045 - 71048	Thorax (Chest)
	71100 - 71130	Ribs, Sternum & Sternoclavicular Joint(s)
	72020, 72040, 72070 - 72082	Spine (1-3 views)
QTY	**MAMMOGRAPHY**	
	77053 – 77054, 77061 - 77067	Breast Screening
QTY	**ULTRASOUND**	
	76813 - 76817	Other Fetal Evaluations
	76536 - 76800	Neck, Thorax, Abdomen & Spine
	76830 - 76873	Male & Female Genitalia
QTY	**DEXA SCAN**	

	77080 - 77081	Dual Energy X-ray Absorptiometry

QTY	OTOLARYNGOLOGY/ENT	
	69210	Cerumen Removal
	31231	Nasal Endoscopy
	92511	Nasopharyngoscopy
	30901	Cauterization of Epistaxis
	69200	Removal of Foreign Body in Ear
	69420	Myringotomy
	92552	Pure Tone Audiometry
	92557	Comprehensive Audiometry
	92567	Tympanometry
	10021	Fine Needle Aspiration
	95992	Epley Maneuver
QTY	**LAB**	
	81015	UA Microscopic
	81000	UA Dipstick
	81025	Urine Pregnancy Test
QTY	**OB CARE**	
	59400	Total OB Care (w/2 utz)
	76801 - 76817	Other Fetal Evaluations
QTY	**OPTHAMOLOGY**	
	92002 - 92004	Eye Exam New Patient
	92012 - 92014	Eye Exam & Tx. Established Pt.
	92134	OCT for retina
QTY	**PODIATRY**	
	11720	Debride Nail 1-5
	11055	Trim Skin Lesion
	11721	Debride Nail 6 or more
QTY	**CARDIOLOGY**	
	93306	Transthoracic Echocardiogram (TTE)
	93000	EKG
QTY	**SCREENING**	
	45378 – 45382, 45385	Colonoscopy Screening and Tumor/ Polyp Removal
	G0105 or G0121	Colorectal Screening
	84152, 84153, 84165	Prostate Specific Antigen complexed
	UROLOGY	
	52000	Cystoscopy
QTY	**PAIN MANAGEMENT**	
	G0480 – G0483	Drug Test 1-7 Classes, 8-14 Classes, 15-21 Classes, and 22+ Classes
	80307	Drug Test PRSMV Chem Anlyzr

QTY	MISCELLANEOUS	
	11010	Debride skin at fx site
	11011	Debride skin musc at fx site
	11042	Debride skin tissue 20 SQ CM
	11043	Debride musc/fascia 20 sq cm
	11044	Debride Bone 20 sq
	11045	Debride subq tissue add on
	11046	Debride musc/fascia add on
	11047	Debride bone add on
	11055	Trim skin lesion
	11056	Trim skin lesion 2 to 4
	11057	Trim skin lesion over 4
	11102	Tangntl bx skin single lesion
	11103	Tangntl bx skin single each sep/additional
	11104	Punch bx skin single lesion
	11105	Punch bx skin each sep/additional
	11106	Incal bx skin single lesion
	11107	Incal bx skin each sep/additional

Referring Provider Signature_____ **Date**_____

Referring Provider_____ **Phone #**_____ **Fax#** _____

Print name

This form does not guarantee payments by Imperial Insurance Companies, Inc. Responsibility for payment shall be subject to member's eligibility, benefit limitations and the interpretations of benefits under applicable subrogation and coordination of benefit rules. This form is not considered valid if not signed by requested provider. Imperial Insurance Companies requires a copy of this direct referral form to be submitted with the claim for payment. Services must be rendered by an Imperial Insurance Companies contracted provider.

2018 0701

IMPERIAL HEALTH HOLDINGS
MEDICAL GROUP

Direct Access Referral Form

Complete all sections of the form and give original to the member. No additional authorization is needed. Retain copy in patient records.

Member Information

Full Name_____ **Date of Birth**_____ **Gender** ☐ **M** ☐ **F**

Phone Number_____ **Health Plan**_____ **Member ID#**_____

PCP Name_____ **PCP Phone #**_____ **PCP Fax #**_____

Diagnosis

ICD code_____ **Dx description**_____ **ICD code**_____ **Dx description**_____

Requested Specialist/Provider

Name_____ **Specialty** _____

Address_____ **City**_____ **State**_____ **Zip Code** _____

Phone #_____ **Fax #** _____

QTY	OUTPATIENT VISITS (Including Behavioral Health)	
1	99201 - 99204	New Patient Consults
	99211 – 99214	Established Patient Follow-Up **(Up to 3 Visits)**
QTY	**PHYSICAL THERAPY**	
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QTY	**MAMMOGRAPHY**	
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QTY	**ULTRASOUND**	
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QTY	DEXA SCAN	
	77080 - 77081	Dual Energy X-ray Absorptiometry

QTY	OTOLARYNGOLOGY/ENT	
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	92511	Nasopharyngoscopy
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	69200	Removal of Foreign Body in Ear
	69420	Myringotomy
	92552	Pure Tone Audiometry
	92557	Comprehensive Audiometry
	92567	Tympanometry
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	95992	Epley Maneuver
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	UROLOGY	
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	11044	Debride Bone 20 sq
	11045	Debride subq tissue add on
	11046	Debride musc/fascia add on
	11047	Debride bone add on
	11055	Trim skin lesion
	11056	Trim skin lesion 2 to 4
	11057	Trim skin lesion over 4
	11102	Tangntl bx skin single lesion
	11103	Tangntl bx skin single each sep/additional
	11104	Punch bx skin single lesion
	11105	Punch bx skin each sep/additional
	11106	Incal bx skin single lesion
	11107	Incal bx skin each sep/additional

Referring Provider Signature_____ **Date**_____

Referring Provider_____ **Phone #**_____ **Fax#** _____

Print name

This form does not guarantee payments by Imperial Insurance Companies, Inc. Responsibility for payment shall be subject to member's eligibility, benefit limitations and the interpretations of benefits under applicable subrogation and coordination of benefit rules. This form is not considered valid if not signed by requested provider. Imperial Insurance Companies requires a copy of this direct referral form to be submitted with the claim for payment. Services must be rendered by an Imperial Insurance Companies contracted provider. 2018 0701

IMPERIAL HEALTH HOLDINGS
MEDICAL GROUP

Fax form with pertinent medical records and information to:
Telephone #: 1 (626) 655-8820
Fax #: 1 (626) 380-9964

Case Management Referral Form

Date of Referral: | **Telephone #:**

Referring Provider: | **Email:**

Member name: | Date of Birth:

Member address: | Member phone number:

Type of Case Management services needed: (check one)

☐	Case Management

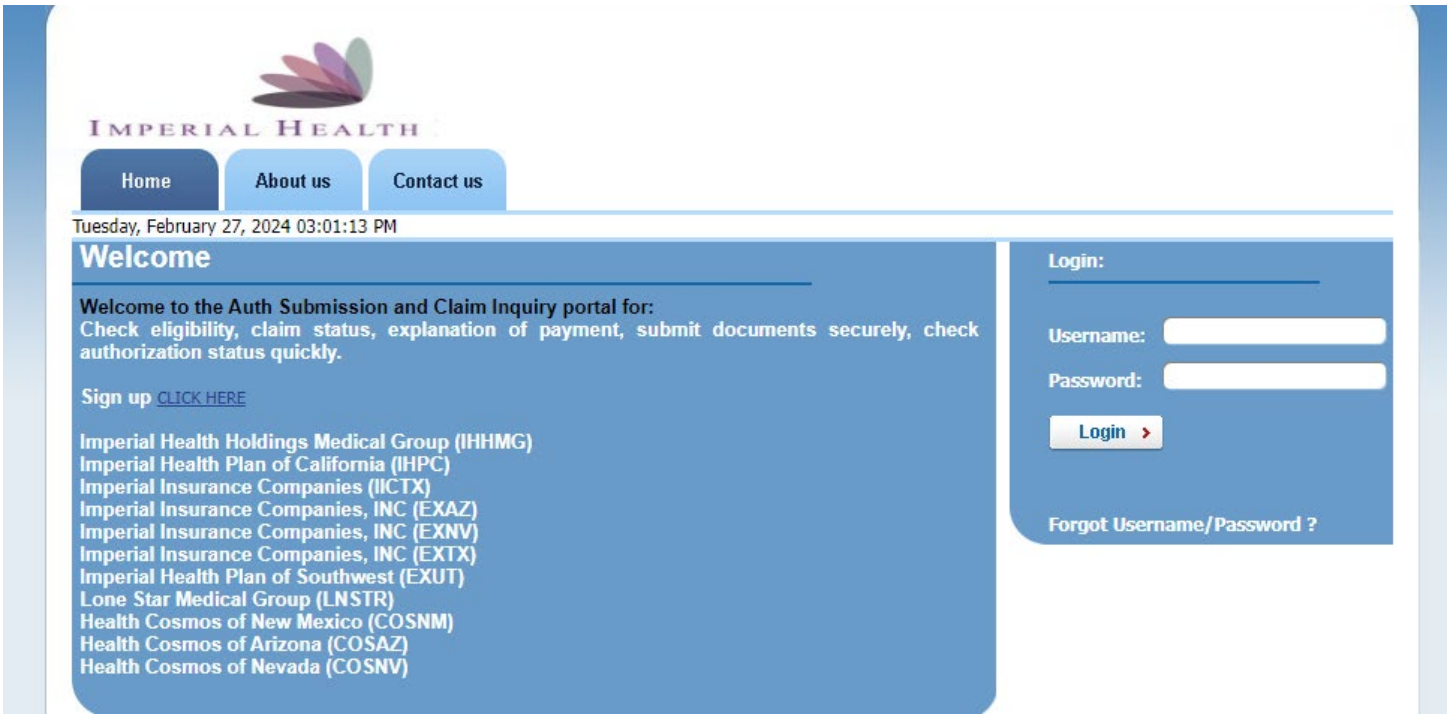
Reason for Case Management Services: (check all that apply)

☐	Difficulty controlling symptoms	☐	Medication or treatment non-compliance
☐	Assistance with self-management	☐	Poly-pharmacy
☐	Assistance with care coordination	☐	Poorly controlled chronic conditions
☐	Multiple hospital admissions or ER visits	☐	Caregiver or social issues

Primary diagnosis:

Additional information:

EZ-NET PROVIDER PORTAL ACCESS REQUEST



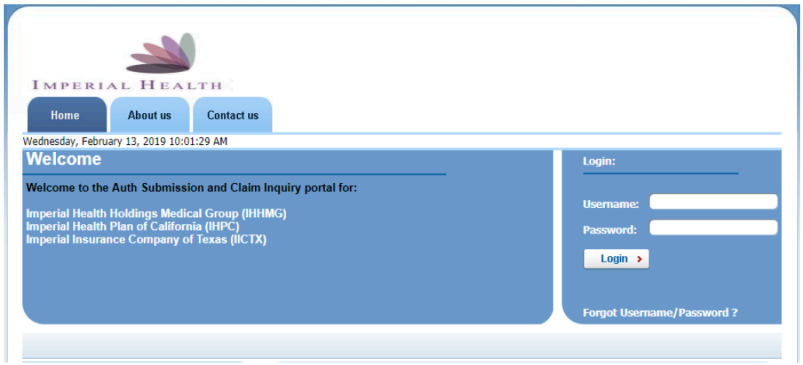
To Sign up for our EZ Net Provider Web Portal follow the link below:

https://forms.office.com/pages/responsepage.aspx?id=5DmEMBsKOESYLX4BxkC_Z8R0IUAAoydBtDaWxFWfGoxUNThYR1pQNzNVNzMwMEY0RDNYRlJVNjZSQS4u

Imperial Health
EZ-Net Provider
Portal Guide

Table of Contents

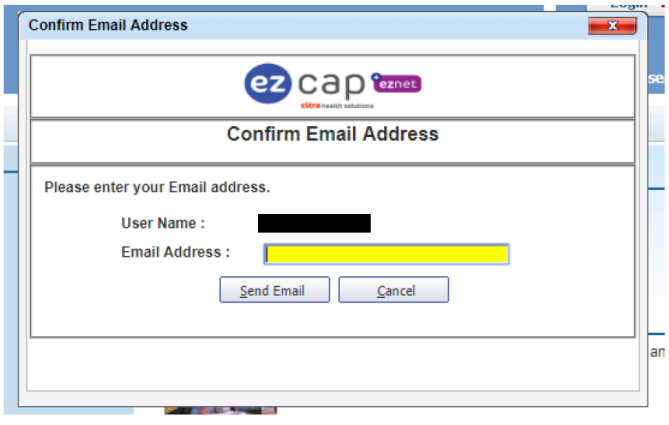
Home Page: https://portal.imperialhealthholdings.com/EZ-NET60/Login.aspx



Input your username and password provided by Imperial.

Only one account will be provided for all staff in your company to use.
Select **Login**.

If this is the first time you are logging in, a window will pop up to confirm a valid company email address. (You can also bypass this window by selecting '**cancel**'.

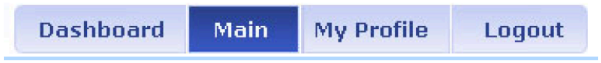


Upon logging in, if you are presented with the following message, you may bypass and continue to the '**Main**' menu tab at the top of the page. The widgets must be configured internally with Imperial and does not prevent the functionality of the portal:

Please Contact Administrator to set your widgets.

Please note the '**My Profile**' tab is <u>not required</u>. That tab is for your own reference on your group and other providers do not see what information is inputted there. Other providers see data that we have on your group from our back end system.

Navigate to the '**Main**' menu tab at the top of the page:



On the '**Main**' menu page, you will have access to view **Providers, Members, Auth/Referrals, Claims, References, Favorites, General.**

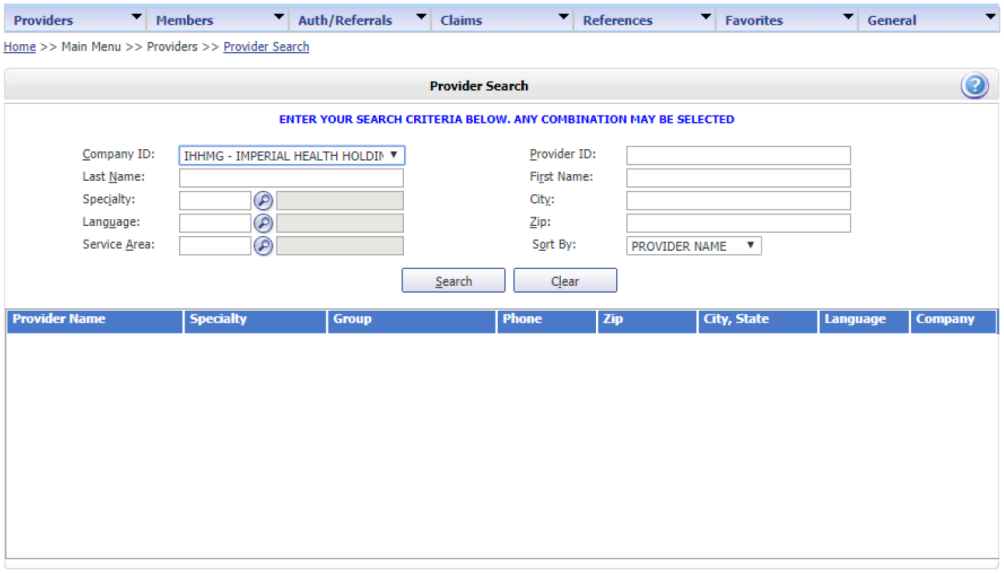
After 30 days, the portal will prompt for a password change. You may continue to use the same password initially given by retyping it in. However, please note that if you change your password entirely, you must inform all your associates who use the portal as well or it will be locked out due to too many failed attempts.

Providers

Search for a Provider

Click on **Provider Search** in the Providers section of the Main Menu to search for providers in **your network operating under the same Tax ID**. To search for a provider, enter any criteria you wish to narrow the results (or leave all fields empty to search ALL providers) and then click on the button.

EZ-NET will display the search result in the window below, sorted in your specified order ("Sort By" dropdown list). If the system does not locate any records that meet your search criteria, a message stating that "NO RECORDS FOUND" will display. Either replace/adjust selection criteria or click on Clear and reenter criteria.



To display provider details, select a provider from the search results list by clicking on the provider name (in BLUE text) in search result screen.

By clicking on a provider name, the user can view the Provider Details screen which contains buttons to also view Assigned Members (Eligibility List), Health Plan Affiliations, and Office Locations.

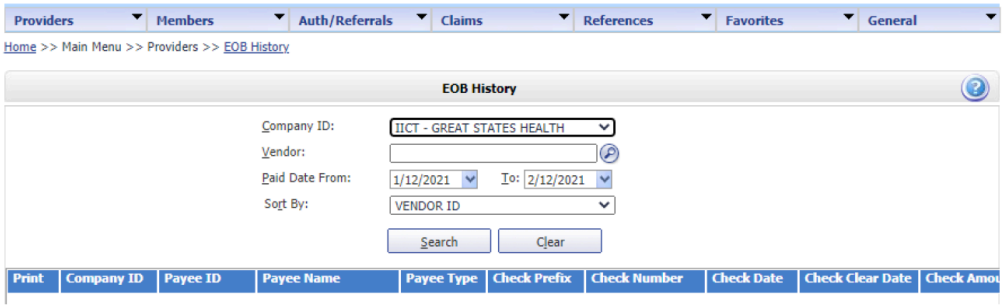
To view all other providers in network with Imperial, you can search via the Auth/Referrals tab when submitting for a member.

EOB History

Search for Explanation of Benefits

Click on **EOB History** in the Providers section of the Main Menu to search for EOB's on file. To search for an EOB, enter the from/to date criteria to narrow the results and hit search.

Each portal account is linked to only **one** Tax ID number. If your group operates under multiple Tax ID's, a new portal application and profile is required for each entity.

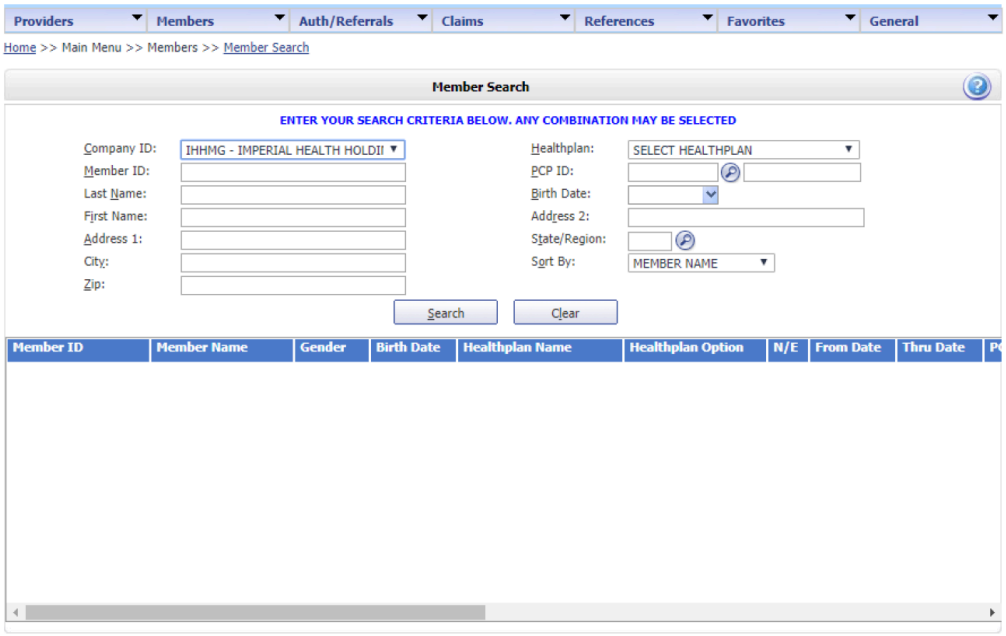


Members

Search for a Member

Click on **Member Search** in the Members section in the Main Menu to search for members. To search for a member, enter any criteria you wish to narrow the results (or leave all fields empty to search ALL members) and then click on the button.

EZ-NET will display the search result in the window below, sorted in your specified order ("Sort By" dropdown list). If the system does not locate any records that meet your search criteria, a message stating that "NO RECORDS FOUND" will display. Either replace/adjust selection criteria or click on Clear and reenter criteria.



Member Eligibility

Member eligibility status is required to be checked with the member's health plan directly.
You may also however navigate to the Members>Eligibility tab and search via Member ID.

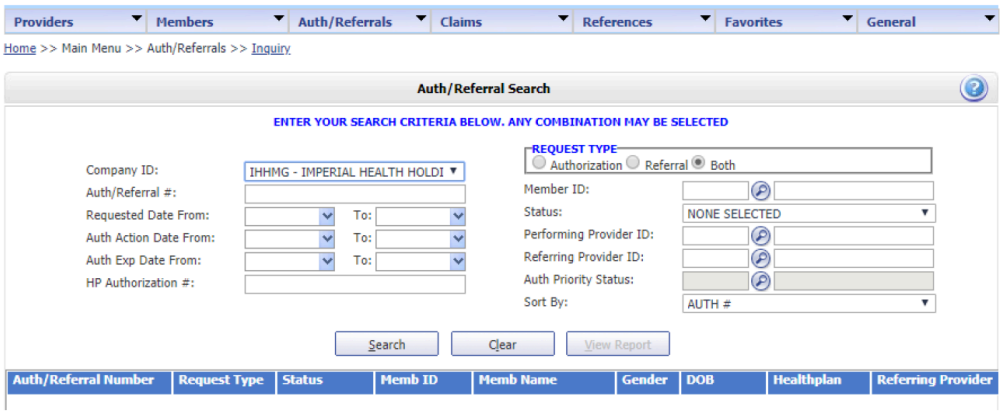
Authorizations & Referrals

Hover the mouse over the **Auth/Referral** tab and select either, '**Inquiry**', '**Auth Submission**' (for Specialists) or '**Referral Submission**' (for PCP).

An EZ-NET user can inquire about an authorization/referral status and view an authorization/referral history.

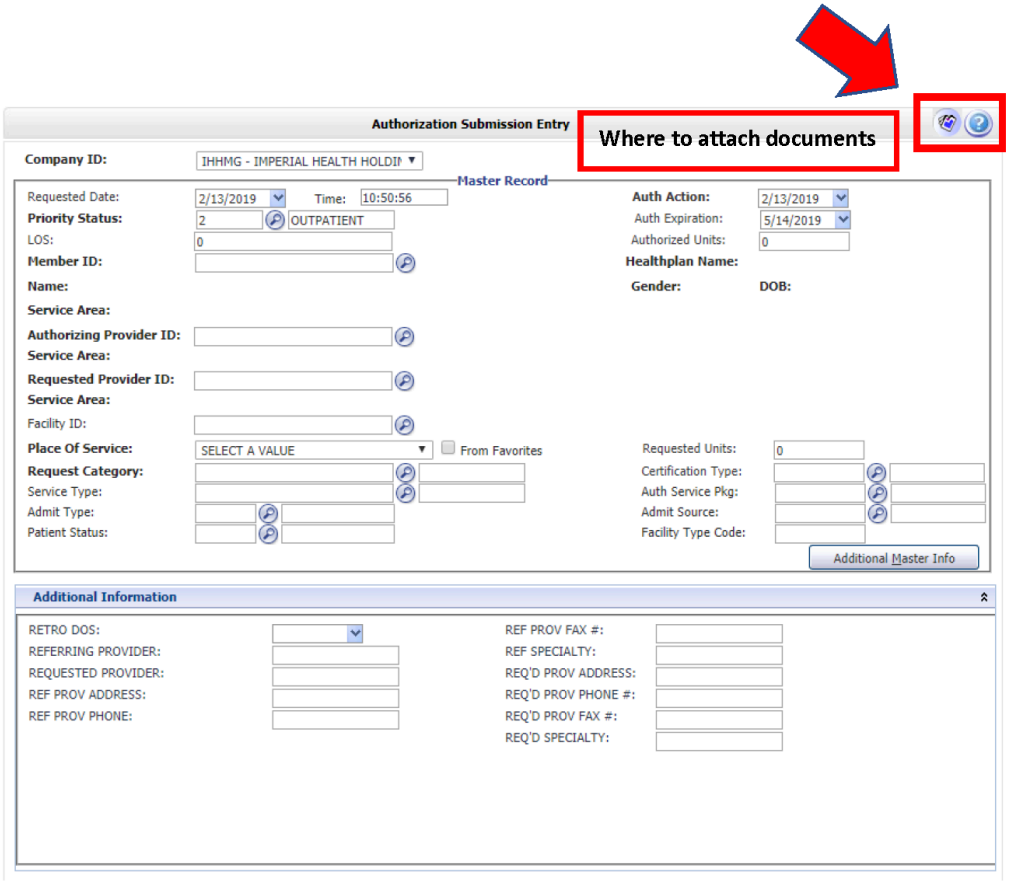
Inquiry

To begin an inquiry, select the **Inquiry** option under the Authorization section of the Main Menu to display the "Authorization/Referral Search" screen. EZ-NET will display the search result(s) in the window below, sorted in your specified order ("Sort By" drop-down list). If the system does not locate any records that meet your search criteria, a message stating that "NO RECORDS FOUND" will display. Either replace/adjust selection criteria or click Clear and re-enter criteria.



Authorizations/Referrals

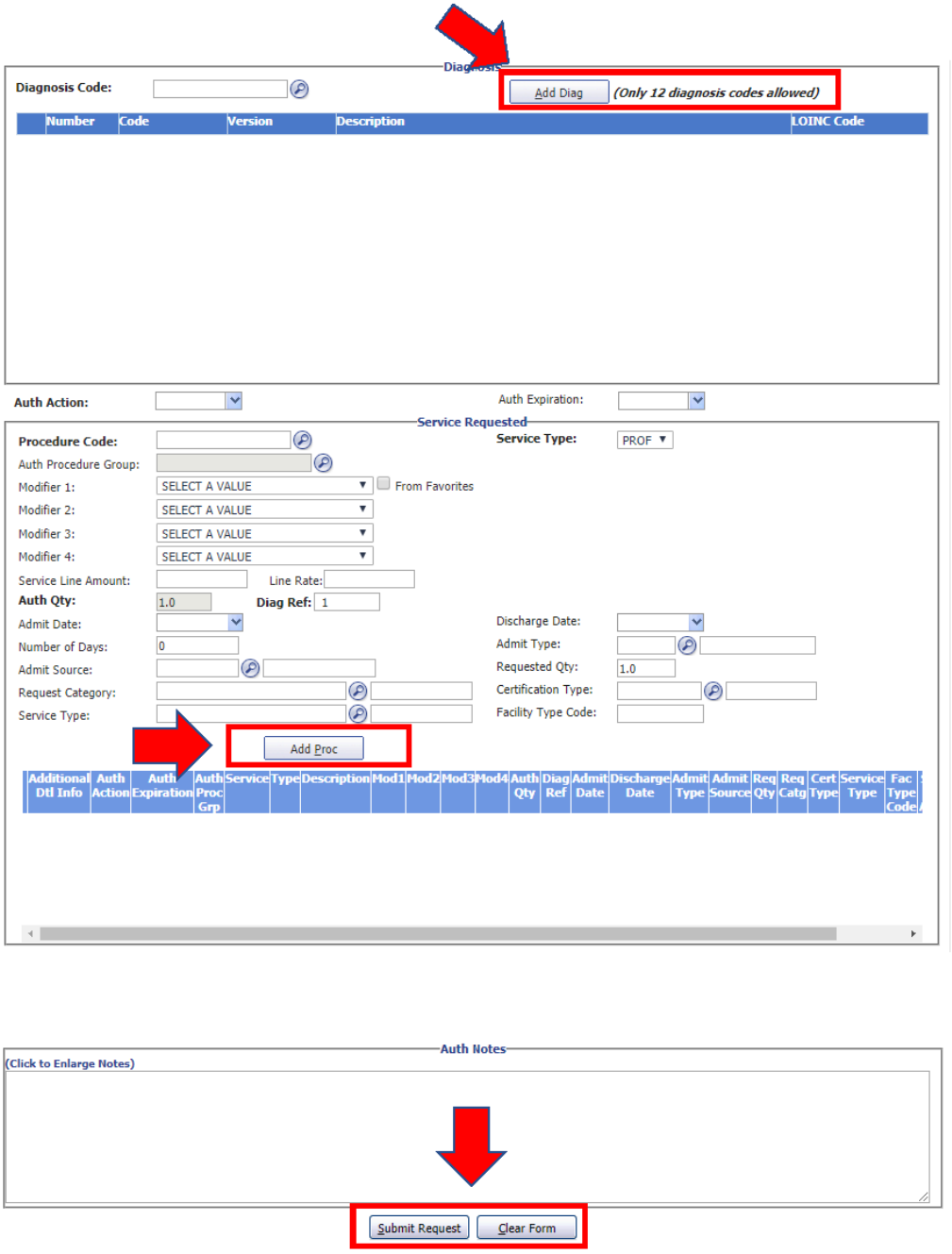
From the Authorization and/or Referral search window, the user can access additional authorization details, referral details, member details, and Referring Provider details.



When the Authorization and/or Referral Details page is displayed, the user may add documents, notes, and memos (**using icons in upper right of screen**) if this has been enabled in EZ-NET Company Configuration (Authorization Details screen shot shown above/below).

Authorization requests can be submitted by the user directly through the EZ-NET system. Prior to submitting an authorization and/or referral, the user may add documents (**using document management icon in upper right of screen**) if this has been enabled in EZ-NET Company Configuration. To begin a submission, click Submission in the Authorization section of the Main Menu to display the Authorization or Referral Submission window (Referral Submission screen shot shown below). Fill in all the required fields and click on the button to submit the request.

Be sure to fill out all required fields in **bold**. If you are not sure of which **contracted** provider to request, please search for '**Unknown Provider**' for submission. (Provider ID: 1316498447).


Diagnosis
Diagnosis Code:
Add Diag
(Only 12 diagnosis codes allowed)
Number
Code
Version
Description
LOINC Code
Auth Action:
Auth Expiration:
Service Requested
Procedure Code:
Service Type:
PROF
Auth Procedure Group:
Modifier 1:
SELECT A VALUE
From Favorites
Modifier 2:
Modifier 3:
Modifier 4:
Service Line Amount:
Line Rate:
Auth Qty:
1.0
Diag Ref:
1
Admit Date:
Discharge Date:
Number of Days:
0
Admit Type:
Admit Source:
Requested Qty:
1.0
Request Category:
Certification Type:
Service Type:
Facility Type Code:
Add Proc
Additional Dtl Info
Auth Action
Auth Expiration
Auth Proc Grp
Service
Type
Description
Mod1
Mod2
Mod3
Mod4
Auth Qty
Diag Ref
Admit Date
Discharge Date
Admit Type
Admit Source
Req Qty
Req Catg
Cert Type
Service Type
Fac Type Code

Auth Notes
(Click to Enlarge Notes)
Submit Request
Clear Form

Once all the information has been entered and selected, review the data entered the Authorization or Referral Submission Entry form. Submit the form by clicking the button at the bottom of the page. The notification dialog box will display the submission status. To review details of an authorization, click on the line that says "Your authorization or referral number is: ####################" to display the Authorization/Referral Details screen.

Please note that all required medical record documents **MUST** be attached to the auth **prior** to submission for review. Authorizations and Referrals submitted **cannot** be modified and a new request will have to be submitted. **CPT codes/quantity adjustments cannot be modified after submission**.

Please ensure that your request is accurate as we must process it as we receive it.

Turn-Around Times

Medi-Cal Standard: 5 Business Days

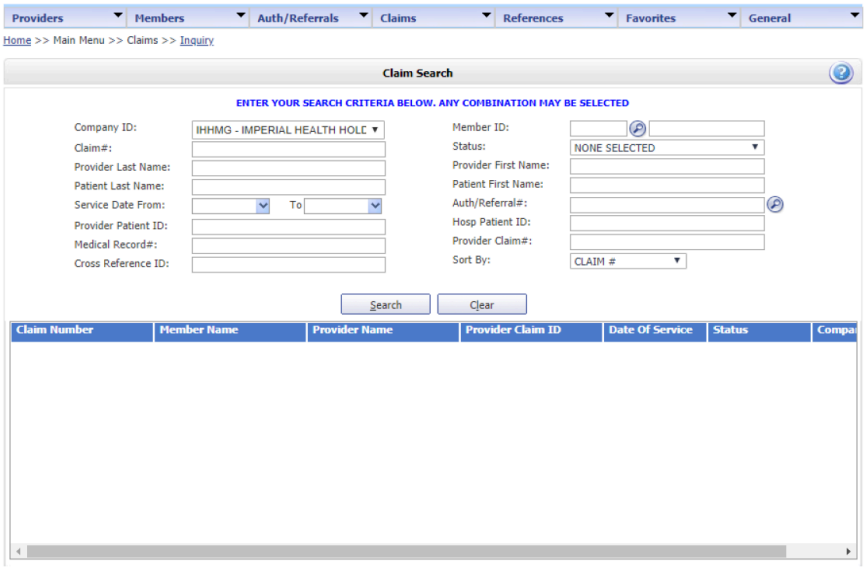
Medicare Standard: 14 Calendar Days

Urgent: 72 Hours (Medically necessary)

Claims

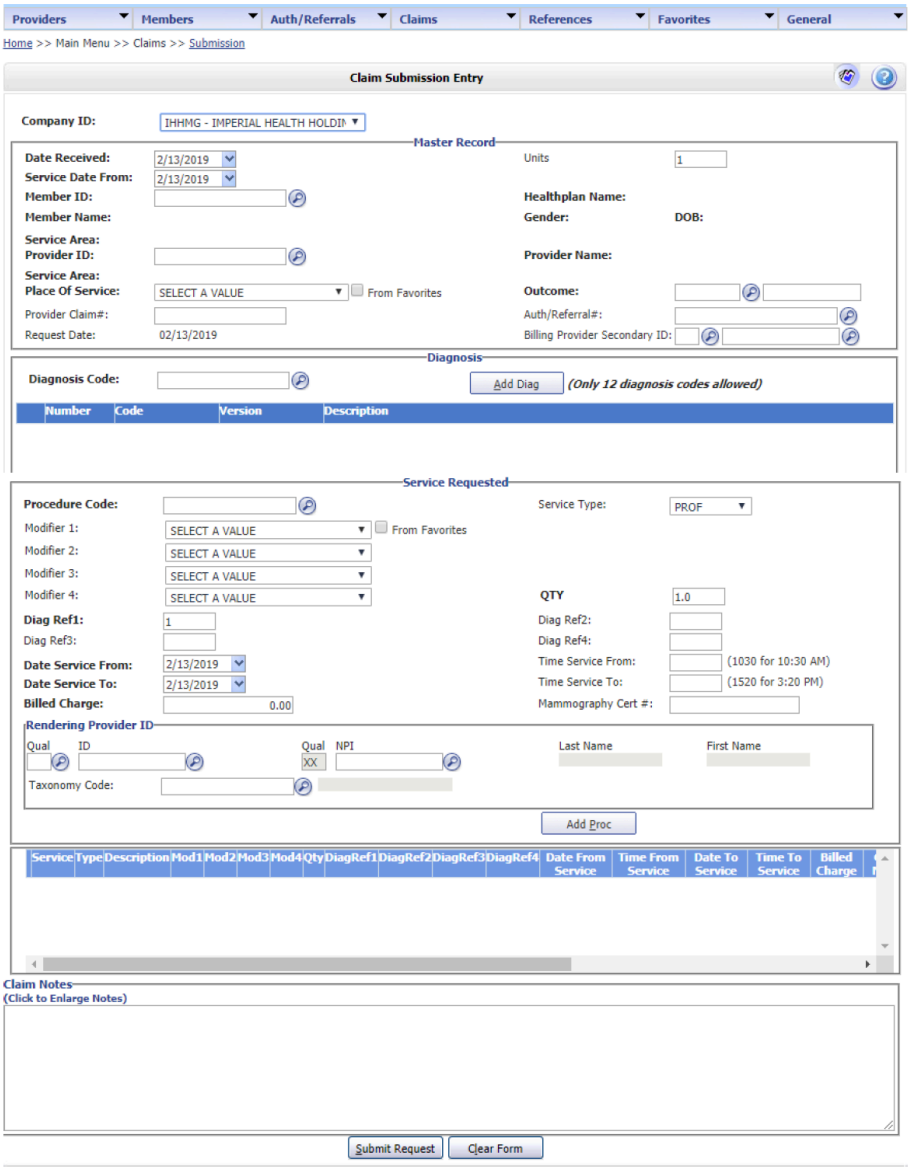
Inquiry

The Claim Inquiry screen is where a user can look up claim to inquire on the status of a submitted claim. This will provide claim submission details when the user clicks on one of the claims listed in the table at the bottom of the screen once a search is performed. To begin an inquiry, click **Inquiry** in the Claims section of the Main Menu to display the Claim Search window.



To view an appeal in process, you will follow the same steps as above and will then see two identical claim numbers differentiated by a few digits. One claim is the original and the other is the appeal in process.

Submission Claim requests can be submitted by the user directly through the EZ-NET system. To begin a submission, click Submission in the Claims section of the Main Menu to display the Claim Submission Entry window. Fill in the all the required fields and click on the button to submit the request.



Review data entered the Claim Submission Entry form and then submit the form by clicking the button at the bottom of the page. The notification dialog box will display the submission status. To review details of a claim, click on the line that says "Your claim number is: ####################" to display the Claim/Encounter Details screen.

Claims Appeal Submission is not yet enabled. Our claims department requests all appeals to be sent in physically to our corresponding PO Boxes.

Reports

To download a report on claim details, navigate to the '**Reports**' tab under the '**Claims**' tab and change the '**Available Reports**' to either: **Claims Paid by PCP ID, PCP Member, Capitation EOB, Cap Payment.**

P.O. Boxes

All claim mail submissions must be sent to the correct mailing addresses based on company:

Imperial Health Holdings
P.O. Box 60075, Pasadena CA 91116

Imperial Health Plan of California
P.O. Box 60874, Pasadena CA 91116

Imperial Insurance Companies, Inc.
P.O. Box 60160, Pasadena CA 91116

Electronic requests must use Office Ally with Payer ID's: **IHHMG** (IPA), **IHP01** (CA Health Plan), **IICTX** (Texas).

Turn-Around Times

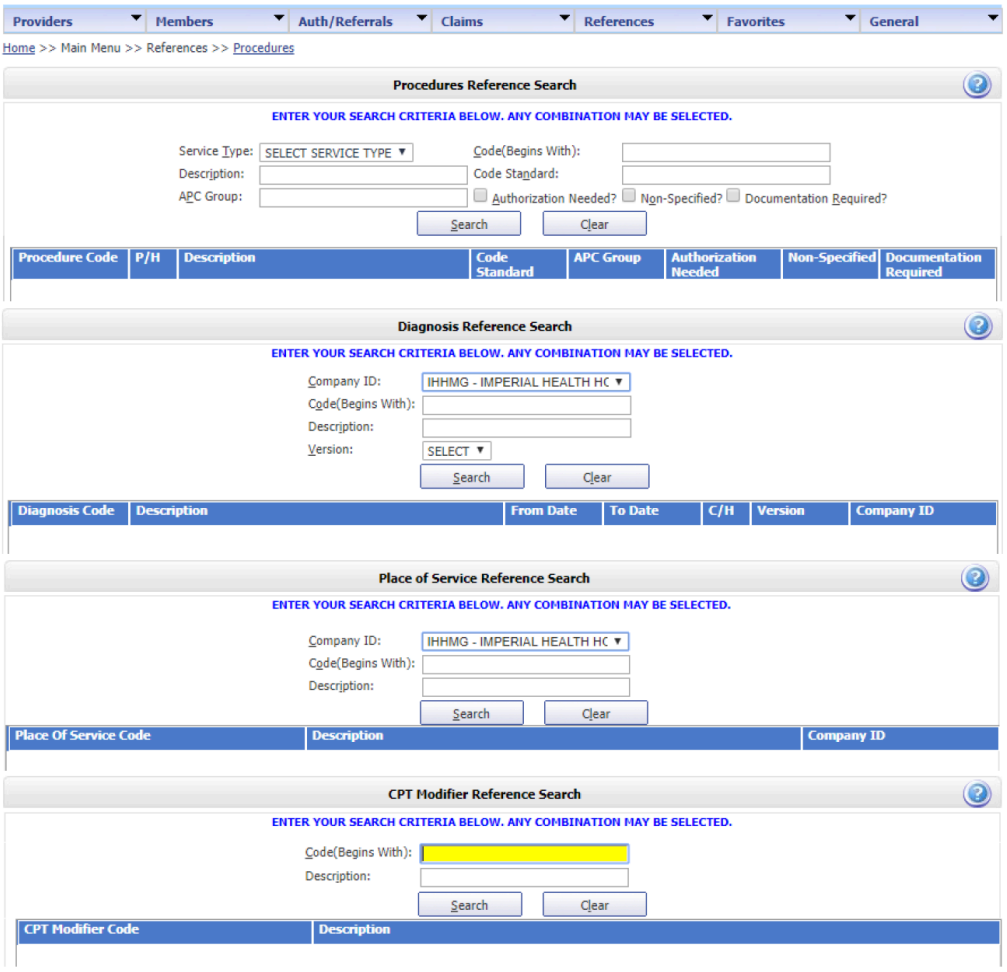
Medicare Non-contracted: 30 Calendar Days Clean Claims
Medicare Non-contracted: 60 Calendar Days Clean Unclean
Medicare Contracted: 60 Calendar Days
Medi-Cal: 30 Calendar Days
Medi-Cal: Provider Dispute Resolution: 45 working
Medicare Non-Contacted Providers: 30 calendar days
Medicare Contracted: Reconsideration-Appeals-Reopening

Medi-Cal:
2 working days of the receipt of an electronic claim
15 working days for the receipt of a paper claim

References

Reference Codes & Contacts

To access EZ-NET system references select one of the following options from within the "**References**" section on the Main Menu: **Procedures, Diagnosis, Place of Service, CPT Modifiers or Contacts**. When you select any of these, a search criteria dialog box will be displayed. For Contacts, use Contact Type = Customer Service.



Contacts

Corporate Office Address:
1100 E Green St, Pasadena CA 91106

Corporate Phone Number:
Imperial Health Holdings Medical Group: (626) 838-5100
Imperial Health Plan of California: (626) 708-0333
Imperial Insurance Companies, Inc.: (626) 708-0333

Corporate Fax Numbers:
Main Fax: (626) 521-6028
Customer Services: (626) 380-9129
Claims: (626) 380-9954
Utilization Management (Outpatient): (626) 283-5021
Utilization Management (Inpatient): (626) 380-9134
Provider Network Operations: (626) 380-9142
Imperial Health Plan (IHP): (626) 205-9536
Imperial Insurance Companies, Inc. (IICTX) PNO: (214) 452-1907

Corporate Extensions:
Utilization Management: Ext 1
Member Services: Ext 2
Claims: Ext 3
Contracting: Ext 4
Provider Services: Ext 5
Eligibility: Ext 6

Customer Service Turn-Around Times:
Voicemail call-backs: 48 Hours

Portal Issues/Concerns:
Provider Network Operations: pno@imperialhealthholdings.com

Imperial Health Plan of California .

Member Satisfaction Survey

1. How long did you wait to get an appointment

To see your primary care doctor †within 1 week †1-2 weeks †3 weeks †4 or more weeks To see a

Specialist †within 1 week †1-2 weeks †3 weeks †4 or more weeks

2. How long did you wait to see your physician once you have arrived at his/her office (past your appointment time?) †0-30 Minutes †30-60 Minutes †More than an hour

3. Was the front office staff courteous to you? †Yes †No

4. Was the back-office staff courteous to you? †Yes †No

5. Was your physician courteous to you? †Yes †No

6. What is your overall satisfaction with the care and service provided through your physician and his/her medical group? †Very satisfied†Satisfied†Dissatisfied

7. Would you recommend your physician to family and friends?†Yes †No

8. How long did you wait to get an answer on your referrals from Imperial Insurance Companies?

†1-3 Days †4-5 days †More than 5 days†Not applicable

9. How satisfied were you with the services provided by your specialist: †Very satisfied†Satisfied† Dissatisfied †Not applicable

10. How satisfied were you with the case management services provided: †Very satisfied†Satisfied† Dissatisfied †Not applicable

11. Did your provider help you regarding your treatment? †Yes†No

12. How long did you wait to resolve your grievance? †within 1 week †1-2 weeks †3 weeks †4 or more weeks†Not applicable

13. How long did you wait to get your claims paid? †within 1 week †1-2 weeks †3 weeks †4 or more weeks†Not applicable

14. Did your provider explain to you about your rights and responsibilities as a Patient?†Yes †No

15. Did your provider give health education materials/referral for your health concern?†Yes †No

16. Did your provider address your cultural and linguistic needs in providing information about your health concern and in providing your referral for other services?†Yes †No

17. Did your provider give you free interpreter information/referral for your health concern?

†Yes †No

Additional comments: _____

Your primary care physician's name: _____

Please return survey to: Imperial Health Plan of California 1100 E. Green St. Pasadena, CA 91106.

Imperial Health Plan of California
PO Box 60874
Pasadena, CA 91116-6874

2024 PROVIDER SATISFACTION SURVEY

Please take a few minutes to fill out this survey on the timeliness and quality of the service you receive from Imperial Health Plan of California and FAX it back to 626-283-5022. Thank you for your participation.

ADMINISTRATIVE SECTION

Provider Network Operations

1. I have been supplied with:

A Provider orientation YES ☐ NO ☐
Access to the Web Portal YES ☐ NO ☐

2. My Provider Network Administrator is knowledgeable and able to answer my questions Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

3. My Provider Relations Representative responds to my needs or concerns in a timely manner

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

Claims

4. My claims are processed in a timely manner

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

Claims inquiries are answered promptly

5. Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

6. Are you aware IICTX accepts electronic claims submission through OfficeAlly?

YES ☐ NO ☐

Capitation

7. My capitation payments are processed in a timely manner.

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

8. My capitation payments I receive from IICTX are accurate

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

9. Are my capitation payments paid according to contract rate?

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

Utilization Management

10. UM Representatives are helpful

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

11. Referrals are processed in a timely manner

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

12. Denial notifications consistently provided denial reasons

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

Credentialing

13. The Credentialing process occurred in a timely manner

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

14. Did I receive appropriate notice on need to Re-credential?

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

15. Credentialing Coordinator is courteous and knowledgeable

Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐

Please provide additional comments or suggestions:

_____

_____

_____

_____

_____

Thank you for taking the time to fill out our survey. We rely on your feedback to help us improve ~~our~~ services. Your input is greatly appreciated.

HEDIS 2024 Gaps In Care

Dear Provider,

Attached is your HEDIS 2024 Gaps In Care report, columns marked with “N” indicate that service is required. Please remind and schedule patients to complete their annual wellness visit and refer to the Imperial HEDIS 2024 guide for best practices and coding tips. If the member has already been seen this year and service was completed for columns marked “N” please fax the supporting documentation or medical record to our QI team.

Sincerely,

Quality Improvement & Analytics
E-mail: Quality@imperialhealthplan.com
Fax: 626-380-9121

IMPERIAL
HEALTH PLAN
OF CALIFORNIA

2024 HEDIS Guide

Table of Contents

*The listed sample codes are not inclusive and do not represent a complete list of codes

INITIAL HEALTH ASSESSMENT (IHA)

DESCRIPTION	
A comprehensive assessment completed during a newly enrolled member's initial visit with a selected or assigned primary care provider. • IHA must be completed within **120 days** of enrollment and documented in the patient's medical record.	
ICD-10 CODES	
Z00.00, Z00.01, Z00.121, Z00.129, Z00.8	
CPT CODES	
Outpatient	9201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 9391-99397
HCPCS CODES	
Outpatient	G0402, G0438, G0439, G0463, T1015

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- Comprehensive history
  - History of present illness
  - Past medical history
  - Review of organ system
- Preventive screening services
- Comprehensive physical and mental status exam
- Diagnosis and plan of care
- Completed Staying Healthy Assessment questionnaire ***required by DHCS**

BEST PRACTICES

1. Review list of newly enrolled patients and call to schedule an appointment
2. Submit timely encounters with proper ICD-10 and outpatient visit codes
   a. ICD-10 code for chronic conditions should be submitted to the highest specificity

Resource	URL

*The listed sample codes are not inclusive and do not represent a complete list of codes

taying Healthy Assessment Tool	ttps://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx

*The listed sample codes are not inclusive and do not represent a complete list of codes

ANNUAL WELLNESS VISIT (AWV)

MEDICARE

DESCRIPTION	
Yearly visit to develop or update a personalized prevention plan and perform a health risk assessment.	
ICD-10 CODES	
No abnormal findings	00.00
With abnormal findings	00.01
HCPCS CODES	
Welcome	G0402
Initial	G0438
Subsequent	G0439

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- Height, weight, BMI, blood pressure, and other measurementsdeemed appropriate
- Medical and family history
- Assessment of preventable diseases with risk and treatment options
- Assessment of cognitive impairment
- Depression screening
- Updated list of prescriptions and medications
- Health Risk Assessment:
  - Demographic data (*e.g., age, gender, race, ethnicity*)
  - Self-assessment of health status, frailty, and physical function
  - Psychosocial and behavioral health risks
  - Activities of daily living
- Assessment of functional ability and level of safety (*e.g., fall risk, hearing, home safety*)
- Checklist or schedule of preventive screenings for the next 5-10 years

*The listed sample codes are not inclusive and do not represent a complete list of codes

BEST PRACTICES

1. Remind and schedule patients for annual office visits
2. Educate and vaccinate patient for influenza yearly
3. Submit timely encounters with appropriate ICD-10 and HCPCS codes

*The listed sample codes are not inclusive and do not represent a complete list of codes

ANNUAL PHYSICAL EXAM

MEDICAID | COMMERCIAL

DESCRIPTION	
Routine physical checkup with the following requirements: • Record height, weight, and BMI/BMI percentile • Record blood pressure and other vitals as needed • Review medical and family history • Assess risk factors for preventable diseases • Perform head, neck, lung, abdominal, and neurological exam • Test reflexes • Submit urine and blood samples for lab testing (as needed)	
CPT CODES	
New patient	9381-99387
Established patient	9391-99397

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- See description above for documentation requirements

BEST PRACTICES

1. Remind and schedule patients for annual office visits
2. Educate and vaccinate patient for influenza yearly
3. Submit timely encounters with proper coding

*The listed sample codes are not inclusive and do not represent a complete list of codes

ADOLESCENT WELL-CARE VISITS (AWC)

MEDICAID | COMMERCIAL

DESCRIPTION
Patients 12-21 years of age who had one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the year of 2020.

ICD-10 CODES	
Well-Care	00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2
CPT CODES	
Well-Care (Ages 12-17)	9384 (new) **or** 99394 (established)
Well-Care (Ages 18-39)	9385 (new) **or** 99395 (established)

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- Health history
- Physical exam
- Physical health development
- Immunization history
- Mental health developmental history
- Health education/anticipatory guidance

BEST PRACTICES

1. Identify patients who have not completed their well-care visit and call to schedule an appointment
2. Submit timely encounters with proper coding

*The listed sample codes are not inclusive and do not represent a complete list of codes

ADULT BMI ASSESSMENT (ABA)

DESCRIPTION	
Patients 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented in years 2019 or 2020.	
ICD-10 CODES	
BMI Percentile (Age 18-19)	68.51 - Z68.54
BMI Value (Age 20-74)	68.1, Z68.20-Z68.39, Z68.41-Z68.45
CPT CODES	
Outpatient	9201-99205, 99211-99215, 99241-99245, 99341-99345
HCPCS CODES	
Outpatient	G0402, G0438, G0439, G0463, T1015

Exclusion codes: *Pregnancy*

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- For members 20 years of age or older
  - Weight and calculated BMI value
- For members 18-19 years of age
  - Height, weight, and BMI percentile documented as a value

BEST PRACTICES

1. Schedule patients for an annual office visit
2. BMI value/percentile must be calculated and noted in patient's medical record
   - **Documentation of height and weight alone will not satisfy this measure**
3. Submit timely encounters with proper ICD-10 and outpatient visit codes

*The listed sample codes are not inclusive and do not represent a complete list of codes

Resource	URL
Adult BMI alculator	ttps://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html
MI ercentile Calculator	ttps://www.cdc.gov/healthyweight/bmi/calculator.html

*The listed sample codes are not inclusive and do not represent a complete list of codes

BREAST CANCER SCREENING (BCS)

DESCRIPTION
Women 50–74 years of age who had a mammogram to screen for breast cancer between October 2018 and December 2020.
CPT CODES
Mammography 7055-77057, 77061-77063, 77065-77067

***Exclusion codes**: Absence of Left Breast, Absence of Right Breast, Advanced Illness, Bilateral, Mastectomy, Frailty, History of Bilateral Mastectomy, Unilateral Mastectomy*

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Copy of radiology report and documentation of historic mammogram results with date of service between 10/1/2018 – 12/31/2020

BEST PRACTICES

1. Educate patients on breast cancer prevention
2. Review findings and document history of a mammogram performed within the last 2 years
3. Refer patient to radiologist and schedule for a mammogram
    a. Schedule a follow-up visit with patient to review results
    b. Document completed mammogram in progress notes with date of service and result of the screening

*The listed sample codes are not inclusive and do not represent a complete list of codes

CERVICAL CANCER SCREENING (CCS)
MEDICAID | COMMERCIAL

DESCRIPTION	
Women 21-64 years of age who completed a Pap smear (cervical cytology) in years 2018-2020 **Or** Women 30-64 years of age who had a Pap smear (cervical cytology) and human papillomavirus (HPV) co-testing performed in years 2016-2020	
HCPCS CODES	
Cytology	G0123, G0124, G0141, G0143, G0145, G0147, G0148, P3000, P3001, Q0091
HPV Co-testing	G0476
CPT CODES	
HPV Co-testing	7620-87622, 87624, 87625

***Exclusion codes**: History of Hysterectomy, Acquired Absence of Cervix w/ Remaining Uterus*

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Cervical cytology report/HPV report

BEST PRACTICES

1. Educate patients on cervical cancer prevention
2. Review findings and document history of a pap smear performed within the last 3 years
    a. Schedule the patient for a pap smear or refer patient to an OBGYN provider

*The listed sample codes are not inclusive and do not represent a complete list of codes

CONTROLLING HIGH BLOOD PRESSURE (CBP)

DESCRIPTION		
Patients 18–85 years of age who had a diagnosis of hypertension with their blood pressure adequately controlled (<140/90 mm Hg)		
ICD-10 CODES		
Diagnosis of Hypertension or Hypertensive Disease	10-I16	*code to the highest specificity
CPT II CODES		
Systolic BP < 130 mm Hg	074F	
Systolic BP between 130-139 mm Hg	075F	
Diastolic BP < 80 mm Hg	078F	
Diastolic BP between 80-89 mm Hg	079F	
CPT CODES		
Outpatient	9201-99205, 99211-99215, 99241-99245, 99341-99345	
HCPCS CODES		
Outpatient	G0402, G0438, G0439, G0463, T1015	

***Exclusion codes**: Acute Inpatient, Advanced Illness, ESRD, ESRD Obsolete, Frailty, Inpatient Stay, Kidney, Transplant, Non-acute Inpatient Stay, Observation, Pregnancy*

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- Most recent systolic and diastolic blood pressure values in 2020
  - If there are multiple BPs on the same date of service, use the lowest systolic and diastolic BP on that date as the representative BP

BEST PRACTICES

1. Schedule patients for an annual office visit
2. Always re-check blood pressure if initial reading is 140/90 mm Hg or greater
3. Submit timely encounters with proper ICD-10, CPT/CPT II, and out-patient visit

*The listed sample codes are not inclusive and do not represent a complete list of codes

codes

a. ICD-10 code for hypertension should be submitted to the highest specificity

*The listed sample codes are not inclusive and do not represent a complete list of codes

COMPREHENSIVE DIABETES CARE (CDC) – HbA1c Control <8

DESCRIPTION	
Patients 18–75 years of age with diabetes (type 1 and 2) whose had HbA1c testing within the measurement year and most recent HbA1c test has a value < 8.0%	
ICD-10 CODES	
Diagnosis of Diabetes	*code to the highest specificity
CPT II CODES	
HbA1c < 7.0%	044F
HbA1c 7.0 – 7.9%	051F
HbA1c 8.0 – 9.0%	052F
HbA1c > 9.0%	046F

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of most recent HbA1c test
- Lab Report
  - Documentation of results/findings

BEST PRACTICES

1. Schedule regular follow-up with patients to monitor changes and adjust therapies as needed
   a. Add HbA1c & urine microalbumin testing as a standard order for patients diagnosed with diabetes
   b. Refer the patient to an endocrinologist for further diabetic management
2. Submit timely encounters with proper ICD-10, CPT, and outpatient visit codes
   a. ICD-10 code for diabetes must be submitted to the highest specificity

*The listed sample codes are not inclusive and do not represent a complete list of codes

COMPREHENSIVE DIABETES CARE (CDC) – Eye Exam

DESCRIPTION	
Patients 18–75 years of age with diabetes (type 1 and 2) who had screening or monitoring for diabetic retinal disease within the measurement year.	
ICD-10 CODES	
Diagnosis of Diabetes	code to the highest specificity
CPT II CODES	
Retinal Eye Exam Reviewed (Positive)	022F, 2024F, 2026F
Retinal Eye Exam Reviewed (Negative)	023F, 3072F

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- Retinal or dilated eye exam report from an optometrist or ophthalmologist
  - Presence or absence of retinopathy must be documented

BEST PRACTICES

1. Refer patient to an optometrist or ophthalmologist for diabetic retinal exam
2. Review eye exam results with patient and document results in patient's medical record

*The listed sample codes are not inclusive and do not represent a complete list of codes

COMPREHENSIVE DIABETES CARE (CDC) – Nephropathy

DESCRIPTION	
Patients 18–75 years of age with diabetes (type 1 and 2) who had nephropathy screening or monitoring test or evidence of nephropathy within the measurement year.	
ICD-10 CODES	
Diagnosis of Diabetes	code to the highest specificity
CPT II CODES	
Negative for Microalbuminuria	061F
Positive for Microalbuminuria	060F

DOCUMENTATION (SUPPLEMENTAL DATA)

Medical record must include:

- Patient name and date of birth
- Date of service of urine microalbumin test
- Documentation of results/findings

BEST PRACTICES

1. Schedule regular follow-up with patients to monitor changes and adjust therapies as needed
    a. Add HbA1c & urine microalbumin testing as a standard order for patients diagnosed with diabetes
    b. Refer the patient to an endocrinologist for further diabetic management
2. Submit timely encounters with proper ICD-10, CPT, and outpatient visit codes
    a. ICD-10 code for diabetes must be submitted to the highest specificity

*The listed sample codes are not inclusive and do not represent a complete list of codes

COLORECTAL CANCER SCREENING (COL)
MEDICARE | COMMERCIAL

DESCRIPTION
Patients 50-75 years of age who had one of the following screenings for colorectal cancer: ▪ Colonoscopy in 2011 to 2020 ▪ Sigmoidoscopy in 2016 to 2020 ▪ Fecal occult blood test (FOBT, gFOBT, iFOBT) in 2019 to 2020 ▪ FIT DNA test in 2018 to 2020

CPT & HCPCS CODES	
FOBT	82270, 82274, G3028
Flexible Sigmoidoscopy	45330-45335, 45337-45342, 45345-45347, 45349, 45350, G0104
Colonoscopy	44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398, G0105, G0121
CT Colonography	74261-74263, G0213-G0215, G0231
FIT-DNA	81528, G0464

DOCUMENTATION

Medical record must include:

- Patient name and date of birth
- Date of service
- Lab/Pathology reports
    - Documentation of results/findings

BEST PRACTICES

1. Educate patients on the importance of colorectal cancer screening
    a. A colonoscopy every 10 years and stool testing done yearly are shown to have similar effectiveness in identifying colon cancer
2. Refer patient to a gastroenterologist for a colonoscopy
3. Alternatively, have patient complete an immunochemical fecal occult blood test (iFOBT)
    a. Have iFOBT kits readily available in the office to provide to patients during their visit

*The listed sample codes are not inclusive and do not represent a complete list of codes

TRANSITIONS OF CARE (TRC)

&

MEDICATION RECONCILIATION POST-DISCHARGE (MRP)

MEDICARE

DESCRIPTION	
The percentage of discharges from 1/1/2020-12/31/2020 for patients 18 years old and older who had an inpatient admission and discharge with documentation of the following four components: • Notification of Inpatient Admission • Receipt of Discharge Information • Patient Engagement After Inpatient Discharge • Medication Reconciliation Post-Discharge	
CPT CODES	
Transitional care management services (within 14 days of discharge)	9495
Transitional care management services (within 7 days of discharge)	9496
CPT II CODES	
Discharge medications reconciled with the current medication list in the outpatient medical record	111F

DOCUMENTATION

Medical record must include:

- Documentation of receipt of notification of inpatient admission on the day of admission or the following day
- Documentation of receipt of discharge information on the day of discharge or the following day
- Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge
- Medication Reconciliation Post-Discharge: Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days)

*The listed sample codes are not inclusive and do not represent a complete list of codes

BEST PRACTICES

1. Submit timely encounters with proper coding
2. Ensure all components are documented in the medical record

*The listed sample codes are not inclusive and do not represent a complete list of codes

MEDICATION ADHERENCE – BLOOD PRESSURE, CHOLESTEROL, or DIABETES MEDICATIONS

MEDICARE

DESCRIPTION
Percentage of Medicare Part D beneficiaries 18 years or older with a prescription for blood pressure, cholesterol, and/or diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. **"Blood pressure medication"** means an ACE (angiotensin-converting enzyme) inhibitor or and ARB (angiotensin receptor blocker) drug, or a direct renin inhibitor drug. **"Cholesterol medication"** means a statin drug. **"Diabetes medication"** means a biguanide drug, a sulfonylurea drug, a thiazolidinedione drug, a DDP-IV inhibitor, an incretin mimetic or a meglitinide drug. Members who take insulin are not included.

BEST PRACTICES

1. Assess proactively whether the patient is taking medication as prescribed.
    a. Identify & resolve any patient specific adherence barriers
2. Encourage adherence by providing 90-day prescriptions for maintenance drugs.
3. Provide an updated prescription to the pharmacy if your patient's medication dose has changed since their original prescription

*The listed sample codes are not inclusive and do not represent a complete list of codes

STATIN USE IN PERSONS WITH DIABETES (SUPD)

DESCRIPTION
Percentage of Medicare Part D beneficiaries 40-75 years who were dispensed at least two diabetes medication fills who received a statin medication fill during the measurement period and remained on a statin medication of *any intensity* for at least 80% of the treatment period. **"Diabetes medication"** means a biguanide drug, a sulfonylurea drug, a thiazolidinedione drug, a DDP-IV inhibitor, an incretin mimetic or a meglitinide drug. Members who take insulin are not included.

BEST PRACTICES

1. Assess proactively whether the patient is taking medication as prescribed.
    a. Identify & resolve any patient specific adherence barriers
2. Encourage adherence by providing 90-day prescriptions for maintenance drugs.
3. Provide an updated prescription to the pharmacy if your patient's medication dose has changed since their original prescription

*The listed sample codes are not inclusive and do not represent a complete list of codes

STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE (SPC)

DESCRIPTION
The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one *high* or *moderate-intensity* statin medication during the measurement year. Members must have remained on a statin medication for at least 80% of the treatment period.

BEST PRACTICES

1. Assess proactively whether the patient is taking medication as prescribed.
    a. Identify & resolve any patient specific adherence barriers
2. Encourage adherence by providing 90-day prescriptions for maintenance drugs.
3. Provide an updated prescription to the pharmacy if your patient's medication dose has changed since their original prescription

*The listed sample codes are not inclusive and do not represent a complete list of codes

WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE (W15)

MEDICAID | COMMERCIAL

DESCRIPTION	
Patients 15 months of age who had one or more well-child visits with a primary care physician in 2020.	
ICD-10 CODES	
Well-Child	00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.5-Z02.6, Z02.71, Z02.82
CPT CODES	
<12 months	9381 (new) **or** 99391 (established)
12-15 months	9382 (new) **or** 99392 (established)

DOCUMENTATION (SUPPLEMENTAL DATA)

Medical record must include:

- Patient name and date of birth
- Date of service
- Health history, physical exam, physical health development, immunization history, mental health developmental history, and health education/anticipatory guidance

BEST PRACTICES

1. Submit timely encounters with proper coding
2. Identify patients who have not completed their well-child visit and call to schedule an appointment
3. PM160: Extract data from PM160 and submit as an encounter

*The listed sample codes are not inclusive and do not represent a complete list of codes

WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH, AND SIXTH YEARS OF LIFE (W34)

MEDICAID | COMMERCIAL

DESCRIPTION	
Patients 3-6 years of age who had one or more well-child visits with a primary care physician in 2020.	
ICD-10 CODES	
Well-Child	00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.5-Z02.6, Z02.71, Z02.82
CPT CODES	
Age 1-4	9382 (new) **or** 99392 (established)
Age 5-6	9383 (new) **or** 99393 (established)

DOCUMENTATION (SUPPLEMENTAL DATA)

Medical record must include:

- Patient name and date of birth
- Date of service
- Health history, physical exam, physical health development, immunization history, mental health developmental history, and health education/anticipatory guidance

BEST PRACTICES

4. Submit timely encounters with proper coding
5. Identify patients who have not completed their well-child visit and call to schedule an appointment
6. PM160: Extract data from PM160 and submit as an encounter

*The listed sample codes are not inclusive and do not represent a complete list of codes

Revised:July 2022

IMPERIAL HEALTH PLAN OF CALIFORNIA

PO Box 60874

Pasadena, CA 91116

KEY CONTACT LIST

Main Number	(626) 838- 5100
Main Fax	() (626) 380-9142
Eligibility	(800) 708-7903

Utilization Management	(800) 708-8273
Utilization Management	(626) 283-5021

Claims Department	(800) 778-9302
Claims Forwarding Address	PO Box 60874 *Pasadena, CA 91116*
Claims Payer ID (Electronic Submission)	Office Ally: IHP01

Contracting/Provider Services	(800) 830-3901
Contracting/ Provider Service Fax	(214) 452-1190

IMPERIAL HEALTH PLAN OF CALIFORNIA

To check status of referral call:
(626) 838-5100 Option 1

Pre-Certification Referral Form

Please complete all sections and fax with all clinical records to support medical necessity to:

Standard fax: (626)283-5021 or (888)910-4412
Urgent fax: (866)811-0455

CMS Defines an expedited request as a request in which waiting for a decision under the standard time frame could place the member's life, health or ability to regain maximum function in serious jeopardy.

A. MEMBER INFORMATION:

Member Name: (Last, First, Middle)	Member ID Number #		Date of Birth
Primary Care Physician (PCP)	Provider / NPI ID #	Phone Number	Fax Number
Referring Physician	Provider / NPI ID #	Phone Number	Fax Number

B. ICD-10-CM DIAGNOSIS CODE:

	CODE	DESCRIPTION
Primary		
Secondary		
Other		
Other		

C. CPT/HCPCS CODE:

	CODE	DESCRIPTION	QTY	UNITS
1)				
2)				
3)				
4)				

D. REFERRED TO PHYSICIAN / ANCILLARY / FACILITY:

REFERRAL PRIORITY: ☐ STANDARD ☐ URGENT

Urgent referrals are only to be submitted if the normal time frame for authorization will 1) be detrimental to the patient's life or health, jeopardize patient's ability to regain maximum function, or 3) result in loss of life, limb, or other major bodily function. All referrals not meeting urgent criteria will be downgraded to a routine referral request and follow routine turn-around times.

Referred to Physician	Provider / NPI ID #	Phone Number	Fax Number
Referred to Physician Address		Name and Direct Contact # completing this form	
Referred to Ancillary/Facility	Facility / NPI ID #	Phone Number	Fax Number
Referred to Facility Address			

E. SERVICE INFORMATION:

☐ Office ☐ Ambulatory Surgical Center ☐ Outpatient Hospital
☐ Home ☐ DME ☐ Inpatient/Acute ☐ Rehab/LTAC ☐ SNF

Requested Date of Service
Scheduled Admit Date

Payment for referred services is subject to plan benefits and member eligibility at time of service.
Do not combine multiple requests for different specialties in a single fax.

IMPERIAL HEALTH HOLDINGS
MEDICAL GROUP

To check status of referral call:
(626) 838-5100 Option 1

Pre-Certification Referral Form

Please complete all sections and fax with all clinical records to support medical necessity to:

Standard fax: (626)283-5021 or (888)910-4412
Urgent fax: (866)811-0455

CMS Defines an expedited request as a request in which waiting for a decision under the standard time frame could place the member's life, health or ability to regain maximum function in serious jeopardy.

A. MEMBER INFORMATION:

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	CODE	DESCRIPTION
Primary		
Secondary		
Other		
Other		

C. CPT/HCPCS CODE:

	CODE	DESCRIPTION	QTY	UNITS
1)				
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Requested Date of Service
Scheduled Admit Date

Payment for referred services is subject to plan benefits and member eligibility at time of service.
Do not combine multiple requests for different specialties in a single fax.

Policies and Procedures

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure

Subject: Credentialing Program	**Policy Manual:** Imperial Management Administrators Services (IMAS)
Effective Date: May 1, 2016	**Policy Number(s):** 05-01-16-02-001
Reviewed Dates: N/A	
Revision Dates: 5/17/2017, 11/28/2018, 7/24/2019, 5/27/2020, 9/21/20, 3/31/21, 4/1/2021, 5/28/2021, 6/9/2021, 11/19/2021, 8/11/2023, 10/3/2023, 3/15/2024, 4/12/2024	**Department: CREDENTIALING**
	Title: Credentialing Manager
Last Revised by: Denise McMillian	**Approval Signature:** On File

SCOPE

Imperial Management Administrators Services (IMAS) herein and throughout the policies shall cover the following entities:

- IMAS
- Imperial Health Holdings Medical Group
- Imperial Insurance Companies
- Imperial Health Plan of California
- HealthCosmos Medical Group – Arizona
- HealthCosmos Medical Group – Nevada
- Lone Star Medical Group

PURPOSE

The purpose of the Credentialing Program is to provide the framework to ensure that healthcare practitioners meet minimum credentials and performance standards. Implementing credentialing and recredentialing processes is vital to the integrity of the network providing quality health care and services to patients.

Credentialing is completed for practitioner applicants in conjunction with contracting.

POLICY

Authority

IMPERIAL HEALTH HOLDINGS
MEDICAL GROUP

Policy and Procedure

Subject: Medi-Cal Provider Dispute Resolution	**Policy Manual:** Imperial Health Holdings Medical Group
Effective Date: May 1, 2016	**Policy Number(s):** 05-01-16-07-0017
Reviewed Dates: N/A	
Revision Dates: 04/14/2024	**Department: CLAIMS**
	Title: President/Chief Medical Officer/Medical Director
Last Revised by: N/A	**Approval Signature:** On File

SCOPE

Imperial Health Holdings Medical Group shall follow the procedures set forth in this policy.

This policy applies to the Medi-Cal line of business.

PURPOSE

To set forth the policy and procedure for processing all provider claims disputes.

POLICY

It is the policy of Imperial Health Holdings Medical Group to adhere to requirements specified in Sections 1300.71 and 1300.71.38, California Code of Regulations Title 28, Claims Settlement Practices and Dispute Resolution Mechanism, when processing provider claims disputes. Imperial Health Holdings Medical Group shall not impose a deadline for the receipt of a dispute that is less than 365 days from the last date of action.

PROCEDURE

1. Types of Provider Dispute Resolution (PDR) issues. Provider disputes that are submitted to Imperial Health Holdings Medical Group may contain requests to review the following types of issues:

    a. Claim payment or denial. Provider disputes payment or denial of claim for any reasons including timely submission, request for retroactive authorizations, eligibility, etc., are tracked through the PDR Database within the Claims Department.

b. Disagreement with request for overpayment. Provider disputes a request for reimbursement of an overpayment of a claim. The dispute is logged in the PDR database and acknowledged. The dispute is routed to Claims Revenue Recovery for research. Once it is finalized, it is returned to the Claims Specialist for the resolution letter.

c. Contract/DOFR interpretation disputes. When a provider dispute arises from a difference in understanding of a contractual interpretation, fee schedule or any term and condition of the contract, the dispute is reviewed and researched by the Claims Department and when research complete resolution letter is issued.

d. Denial of authorization for "pre-service" requests. When a pre-service dispute is received within the Claims Department, it is directed to the Network UM Department for review and retro-authorization determination. Once claim is received back from UM Department the Claims department issues a resolution letter.

2. Required submission of information. The provider must utilize the PDR Request Form a written notice that contains, at a minimum, the following information:
    a. Provider's name;
    b. Provider's identification number;
    c. Contract information; and
    d. A clear explanation of the disputed item, the date of service and a clear identification of the basis upon which the provider believes the payment amount, request for additional information, and request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect.

3. Receipt of claims. The Claims Mailroom Unit receives all Claims Department mail and is responsible for the sorting, batching, date stamping and inventory of all claim receipts.
4. Provider dispute must be acknowledged within 2 working days if submitted electronically or 15 working days if submitted in paper
5. IHHMG shall not impose a submission deadline of less than 365 days from action or in case of inaction, no less than 365 days after the time for contesting or denying a claim has expired
6. Resolution of Provider Dispute must be made in writing within 45 working days from the receipt of dispute
7. Whenever a payer contests, adjusts or denies a claim it shall inform the provider of the ability to dispute and include the procedure for obtaining forms, along with mailing address for submission of disputes

Initial Review

1. For paper claim disputes, the Claims department makes the initial determination of provider dispute(s) and sends acknowledgement letter(s) within fifteen (15) working days from date received. For electronic claim disputes an acknowledgement letter is sent within two (2) working days from date received.

2. If the Claims department determines that the submitted information is not a PDR, the information is forwarded to Claims Mailroom Unit for batching to Claims Examiners.

3. The Claims department enters the disputed information into the Imperial Health Holdings Medical Group Provider Web Portal. Information from Imperial Health Holdings Medical Group portal is automatically transferred to PDR Database.

4. The database automatically generates an acknowledgement letter based on the data entered above. Once this letter is issued, the data cannot be altered. Acknowledgment letters are sent the same day they are generated.
5. The Claims Specialist prints a tracking form that is generated by the database for each PDR submission. The tracking number is noted in the claims system history for cross-reference.

6. The Claim Specialist batches the PDRs by received date and enters received date and claims count into Inventory Control Database for inventory tracking.

Final Determination

7. The Claims department reviews PDRs based on oldest date on hand.

8. The Claims department reviews the details submitted by the provider to determine if Imperial Health Holdings Medical Group initial, decision should be overturned or upheld.

9. If a dispute is in favor of the provider, payment is issued to the provider within five (5) working days of determination. All applicable interest owed is included in the payment.

10. If additional information is required from a provider, a letter will be mailed to the provider requesting additional information within 45 days of receipt of the dispute. The PDR is held open for an additional 30 working days in order to receive requested information

11. The Claims department maintains all pended receipts and handles responses and non-responses from providers within the required time frame.

12. All final determinations are noted on the tracking form and if the Provider Dispute is overturned or upheld, a determination letter will be mailed to the provider within 45 working days from the date of receipt of the dispute

13. When batch of PDRs have been completed, the Claims department closes the inventory batch in Inventory Control Database.

PDR Database

1. The PDR Database is an internal device that tracks and stores all provider dispute information outside of the claims processing system. This Access database is used to compile and report details of the Provider Dispute Resolution Mechanism established by Imperial Health Holdings Medical Group.

2. All information entered is “backed up” for security purposes.

3. The database is “field” protected. PDR information entered in the database cannot be deleted or altered once it is saved.

4. Reports can be generated to review all data using the PDR Database**.** These reports are generated on the basis of open or closed disputes.

5. The Claims Manager generates reports for monitoring timely acknowledgements and timely completion of disputed receipts.

Note: *The Provider’s Right to Appeal is indicated at the bottom of every Imperial Health Holdings Medical Group’s Explanation of Payment (EOP) issued to a provider.*

Copies of provider disputes and the determinations, including all notes, documents and other information used to reach its decision, shall be retained for a period of not less than ten years.

Reference(s)

- AB1455
- 42 CFR 405.940, 405.942, 405.962, 405.944, 405.964§1852 (a)(2)(A)

Attachment(s)

None

The Board of IMAS is ultimately responsible for supporting the Credentialing program but has delegated authority for implementation of the Program to the Health Plan Credentials Committee.

Contracted participating providers in the network, providing healthcare and services to health plan members must be credentialed. The scope of credentialing includes, but is not limited to: MDs, DOs, DDS, DPMs, and DCs.The credentialing process may also be extended to physicians who are not contracted by the health plan, but who provide coverage for network practitioners. The credentialing and recredentialing of Allied Health Professionals is also included under the scope of the Credentialing Program. This includes LCSWs, Psychologists and MFTs.

Providers are listed in the IMAS Provider directories ONLY after their credentialing has been completed.

Formal selection and retention criteria does not discriminate against health care providers who treat high-risk or high-cost populations and credentialing and recredentialing decisions are not based on criteria of race, religion, gender, age, ethnicity, nationality, sexual orientation or patients (e.g., Medicaid) in which the practitioner specializes. Committee members must sign an attestation form incorporating the above criteria. If complaints regarding discrimination are received from a provider (either verbally or in writing), the matter will be reviewed by the Credentials Committee and referred to the QM department for further evaluation and action. Additionally, procedures for monitoring and preventing discriminatory credentialing decisions may include, but are not limited to:

- Periodic audits of credentialing files (in-process, denied and approved files) to ensure that practitioners are not discriminated against;
- Periodic audits of practitioner grievances/complaints to determine if there are grievances/complaints alleging discrimination;
- Monitoring involves tracking and identifying discrimination in credentialing and recredentialing process; and
- Maintaining a heterogenous Credentialing Committee membership.

IMAS will monitor the effectiveness of the credentialing and re-credentialing processes at least annually for all credentialing activities delegated to contractors.
Credentialing will commence when providers have signed attestations stating that they are not excluded from Medicare/Medicaid participation and/or have chosen not to opt out of Medicare/Medicaid. For providers who are recredentialing, each Credentialing Coordinator will review the appropriate State or Federal website to ensure that providers have not opted out between cycles.

Additionally, IMAS has policies and procedures for the initial and ongoing assessment of organizational entities with which it contracts. This includes, but is not limited to hospitals, skilled nursing facilities, home health agencies and freestanding surgical centers. Assessment is required when the contract is initiated and every three years thereafter.

The scope of the Credentialing Program includes policies that define the oversight and/or credentialing/recredentialing of non-physician extenders, i.e., Physician Assistants, Nurse Practitioners, Certified Nurse Anesthetists and Certified Nurse Midwives. Oversight functions include documentation of valid current licensure and malpractice insurance for both physician and physician extenders to be kept on file with the Credentialing Department. An attestation form confirming compliance with all laws, regulations, standards and contract provisions will be signed by the supervising physician and physician extender and kept on file with the department. Credentialing/Recredentialing functions are included under the Credentialing/Recredentialing Process portions of this document.

Committee Structure

The Credentials Committee will be comprised of the Chair, currently an IMAS Chief Health Officer (CHO), and at least *two* additional physicians: IMAS participating physicians. Imperial Health is comprised of a range of participating practitioners. The Chair is accountable for the credentialing function with the support of the Senior CHO and the Credentials Manager. The Credentialing Chair is available on a daily basis to provide consultation/direction for Credentialing staff in implementing the credentialing processes. The Credentialing Chair also attends the Board of Directors meetings, chairs the QI Committee and UM Committee and attends Managers Meetings, providing linkage between the various components of medical management functions. The Chair is diligent in providing appropriate formal follow-up to participating providers.

IMAS Committee meetings are only conducted with a quorum (3), consisting of the Chair and a simple majority of the Committee physicians. Only physician members are voting members. Non-physician members may include the Managers of Medical Management and the Manger of Credentials or Credentialing Coordinator.

Additionally, the Committee may consult any member on a call list of specialists maintained by the Credentialing Department for input and evaluation of credentialing and/or recredentialing applicants.

The Credentials Committee is scheduled to meet on a quarterly basis and will take Committee action as needed. Minutes are completed for review and signature by the Credentials Chair prior to the next Credentials Committee meeting and stored in a locked cabinet, with access limited to the CHO and Credentials staff.

The Credentials Committee, with the cooperation of the Credentials staff, will maintain copies of all applications, verification reports, office site and medical record audit worksheets, and other data within the provider file. These files are stored in locked cabinets in the Credentials Department and access to the files is limited to Committee physicians during the meetings and Credentialing/QI staff on an as needed basis. Quality/peer review information is maintained in separate files.

Committee Objectives

The objectives of the Credentials Committee are to develop provider networks with health care practitioners meeting established standards of credentialing and re-credentialing.

- To objectively assess credentialing information on all providers against established standards prior to being contracted as part of the provider network.
- To objectively assess re-credentialing information and performance on all providers against established standards every three years.
- To develop and recommend new policies and procedures as needed to meet or exceed the regulatory standards for demonstration of professional competence and verification of other relevant credentialing information.
- To provide a confidential forum for review, discussion, and determination of clinical care issues by committee peers resulting in education, disciplinary actions as appropriate, improved physician performance, and improved patient care.
- To provide oversight on all credentialing and re-credentialing activities.
- To provide oversight for office site review activity as a component of credentialing and re-credentialing.

- To annually review and evaluate the effectiveness of the Credentialing Program.

Confidentiality

Individuals engaged in credentialing activities shall maintain confidentiality of the information disclosed inherent with responsibilities of Committee membership. A "statement of confidentiality" is signed by each physician member and IMAS staff member. The credential staff members also sign confidentiality statements as a condition of their employment and are issued restricted, confidential passwords for on-line credentialing and any interfaces with a possible delegated credentialing organization.

Physician files are kept in locked cabinets, accessible only to Committee physicians during the Credentialing Committee Meetings and Credentialing staff.

Conflict of Interest

No person may participate in the review and evaluation of any case in which she/he has been professionally involved or where individuals who have a business, family, or professional relationship with such a person are involved.

Peer Review

It is the objective of peer review to provide a confidential forum with non-discoverable transaction records in which the discussions of peers and examination of clinical records may lead to enhanced education of the participants, improved physician performance, physician sanctioning as appropriate and improved patient care.

Government/Health Plan Access to Peer Review

Federal and State representatives are allowed minimal access to blinded peer review data as part of the oversight function. All representatives must sign confidentiality statements prior to auditing/reviewing Credentialing information.

Credentialing Process

The credentialing requirements/criteria for contracted participating physicians are as follows (the requirements for allied health professionals are implemented as applicable):

- Completed State Participating Physician Application including the signed attestation statement by the applicant regarding:
    - Ability to perform the essential functions of the position
    - History of loss of license and/or felony convictions
    - History of loss or limitation of privileges or disciplinary activity
    - Attestation to the correctness and completeness or the application
    - Lack of present illegal drug use
    - Authorization to release information for the verification of credentials
    - History of professional liability claims
    - Upon receipt of the CAQH/Texas and Arizona Standardized Applications, the Credentialing Department will date stamp all incoming applications. Applications are reviewed for completeness and the applicant is notified

of missing documentation within 5 business days.
    - All applications must be completed within 90 days of receipt, including Credential Committee Approval.
- Material omissions and /or misrepresentations may result in immediate denial of the application, or termination of privileges, employment or physician participation agreement.
- The highest level of education will be verified for Practitioners; Refers to MD, DO, DPM, PhD, DDS, MFT, LCSW, PA, NP.
- Online primary source verification of Board Certification is obtained within 180 days of Committee determination from the American Board of Medical Specialists (ABMS) or the appropriate certifying Board.
- On-line verification is obtained from the American Osteopathic Association for DOs.
- Primary source verification of educational Medical Company Name (medical school, residency or fellowship training) is required and obtained within 180 days of Committee determination for those practitioners who are not Board Certified.
- Only the highest levels of education must be verified (e.g., residency, fellowship as appropriate). This may be obtained through the American Medical Association (AMA) Physician Master File.
    - If an agent of an approved source (e.g., National Student Clearinghouse (NSC)) is used documentation of the contractual relationship between it and the approved source (i.e., institutions that work with the approved source) that entitles the agent to provide verification of credentials on behalf of the approved source. Documentation of this contractual relationship (e.g., contracted list, screen shot of contract relationship) will be included in the file.
- Online primary source of verification of malpractice history of past or pending suits is obtained from the National Practitioner Data Bank (NPDB) within 180 days prior to Committee determination. NPDB query is not required for chiropractors and podiatrists, however, queries are completed.
- Primary source verification of clinical privileges at the hospital designated by the practitioner as the primary admitting hospital is obtained from the hospital within 180 days prior to Committee determination. Any limitation of privileges must be noted, and confirmation of clinical privileges in good standing is required. A physician is not required to have clinical privileges to be credentialed but must state in writing who is providing inpatient coverage, or it must be noted that a hospitalist program is in place.
- A copy of the certificate of insurance face sheet is required, showing professional malpractice coverage meeting mandated State levels, effective at the time of the Committee determination.
- Verification of current DEA or CDS certificate is completed through a copy of the certificate, effective at the time of the Committee determination. This is done during both the initial/recredentialing cycle. Additionally, DEA validation is part of our Ongoing Monitoring and as such, the active database is queried on a monthly basis to identify any providers with administrative actions.
- Primary Source verification from the applicable State Medical Board and/or a copy of unrestricted State license from the practitioner is obtained within 180 days of Committee determination. For practitioners other than MDs, primary verification must be obtained from the appropriate state licensure agency.
- Online primary source verification of Medicare and Medi-Cal Sanction status is

obtained within 180 days of Committee determination through querying NPDB and/or Federation of State Medical Boards (FSMB).

- For initial credentialing, re-credentialing and ongoing monitoring and reporting of sanctions, verifications shall be verified through Streamline Verify monthly via https://dmf.streamlineverify.com/search. The following websites are verified through Streamline Verify: Federal OIG, System Award Management (SAM), California Medi-Cal Suspended, Texas OIG, Medicare Opt-Out, & NPPES NPI Registry.
- Primary source verification of HIV/AIDs Specialist status is obtained through the American Academy of HIV Medicine (AAHIVM).
- Online primary source verification of state sanctions, restrictions and/or limitation on scope of practice is obtained through the FSMB or query of the appropriate state licensure agency within 180 days of Committee determination.
- References from licensed physicians are required on the application. References may be verified if additional verification of competence is needed.
- Work history of at least 5 years as demonstrated on application or Curriculum Vitae. Any gap in work history beyond six months should be verified orally, and gaps of one year or more should be verified in writing by the practitioner.
- CLIA certificate if required at all facilities to perform any laboratory tests. While this may not be a requirement in all states, IMAS will run a query on all providers during the initial/recredentialing process.
- Social Security Death Master File (SSDMF) during the initial/recredentialing cycle verification shall be performed on each provider during the initial credentialing process and the re-credentialing cycle. Verifications shall be verified at: https://dmf.streamlineverify.com/search
- Medi-Cal Enrollment Verification is validated with California Health and Human Service Open Data Portal Fee for Service or the Ordering, Referring and prescribing (ORP) at initial credentialing and recredentialing.
- **NOTE:** Provider will not be credentialed if they are currently Opted-Out of Medicare.
- **EXPIRABLES -** As a basis to ensure compliance, a report is generated on a monthly basis to identify practitioners whose malpractice, DEA, license, or board certification is due to expire. The Credentials Assistant will contact the practitioner to obtain updated documents and update the Credential file.

Practitioner Right to Review Information

Practitioners are notified of their right to review and correct erroneous information obtained in the credentialing or re-credentialing process. This includes information obtained from any outside primary source (state licensing boards, malpractice insurance carriers). The right to review does not extend to references or recommendations or other information that is peer review protected or if disclosure is prohibited by law. They may also ascertain the status of their application or reapplication at any time.

If credentialing information obtained from other sources varies substantially from that provided by the practitioner, the Credentialing Coordinator will notify the practitioner in writing for their response within five working days or less. A written response is required from the practitioner to be sent to the appropriate Credentialing Coordinator and this information is placed in the chart for review at the time of credentialing/re-credentialing.

Practitioners are notified of these rights in the Provider Manual, in the CHO's communication to practitioners and in cover letters sent to initial applicants and those who are re-credentialing.

Committee/Chief Health Officer Determination

Upon receipt of the required credentialing information, the CHO (for level 1 applicants) and the Credentials Committee (for level 2 applicants) will review and approve the applicants.

Level 1 applicants are presented to the CHO for review and approval. Level One Providers meet all the pre-established criteria for credentialing with no adverse information reported from any primary or other secondary source. There are no active suits or suits pending.

Level 2 completed applicants meet the credentialing criteria but some adverse information has been reported from a primary or other secondary source, there is a new suit, or a suit is pending. *Level 2* applicants will be pre-reviewed by the Chief Health Officer and then presented to the *Imperial Management Administrators Services (IMAS) Credentials Committee for* review and approval. The Chief Health Officer may also approve certain Level 2 applications.

The applicant will be formally notified by letter within 60 days of the CHO/Committee's determination.

The Credentials Committee may recommend that the applicant not be approved due to the provider's conduct or professional competence that may compromise patient safety or the quality of patient healthcare. The applicant will be notified in writing by the Credentials Committee of the reason for such action. Notification to the applicant will be sent within 60 working days.

If the applicant reapplies at some other time, his/her application will be processed as an initial application.

Screening of Excluded Individuals and Downstream or Related Entities

The IPA/Medical Group shall ensure that employees and/or downstream subcontracts and/or related entities are not sanctioned, debarred, suspended, or excluded from participation in Medicare or Medicaid under Sections 1128 or 1128A of the Social Security Act.

The IPA/Medical Group must ensure it has screened its employees and/or subcontractors as required by CMS prior to employment or contracting and at least monthly thereafter against the CMS required exclusion lists: DHHS Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the General Service Administration/System Award for Management (SAM) Excluded Parties Lists Systems (EPLS).

NOTE: Medicare requires the IPA/Medical Group to ensure that no payments are made with respect to any item or service (other than an emergency item or service) furnished by an individual or entity when such individual or entity is excluded from participation in Medicare/Medicaid programs (including Medicare Advantage plans).

Site Audit and Medical Records Review

Office site visits are required as part of the initial credentialing process for all Primary Care Physicians (PCPs). This includes a physical inspection including, but not limited to safety issues,

policies and procedures in place for office, protocols, emergency capabilities and medical record keeping organization. Standards of compliance have been determined as part of this policy at 90% and the results are incorporated into the initial determination for these providers. Outcome letters are sent to the practitioners notifying them of the results and possible opportunities for improvement. Audit tool results are maintained in Credentials files and or Provider Relations files. State Site Audit results may be accepted in lieu of the IMAS audit.

Re-credentialing

Participating providers must satisfy re-credentialing standards required for continued participating in the network. Re-credentialing is completed within three years from the last Re-credential cycle. Providers are Re-credentialed no more than 36 months maximum to maintain compliance.

Primary Source verification of medical licenses, DEA certificates, and malpractice forms will be kept current between re-credentialing cycles. Each form is tracked by expiration date.

The requirements for re-credentialing are:

- CAQH Application, Imperial Profile and W9. The CAQH must have a valid attestation date by the applicant.
- Board Certification if the practitioner states that he/she is board certified. Verification of board certification for chiropractors is not required.
- Online primary source verification of malpractice history of past or pending suits is obtained from the NPDB within 180 days of Committee determination. This does not apply to chiropractors and podiatrists.
- Primary source verification of clinical privileges at the hospital designated by the practitioner as the primary admitting hospital is obtained from the hospital within 180 days of Committee determination.
- Primary source verification of professional malpractice coverage meeting applicable State Standards and /or a copy of the certificate of insurance face sheet, effective at the time of the Committee determination.
- Verification of DEA certification effective at the time of the Committee determination.
- Online primary source verification of medical license from the State Medical Board is obtained within 180 days of prior to Committee determination.
- Online primary source verification of Medicare and Medical Sanction status is obtained within 180 days of Committee determination. This is obtained through NPDB and/or FSMB online query.
- Online primary source verification of state sanctions, restrictions and/or limitations on scope of practice is obtained through the FSMB or query of the appropriate state licensure agency within 180 days of Committee determination.
- Medi-Cal Enrollment Verification is validated with California Health and Human Service Open Data Portal Fee for Service or the Ordering, Referring and prescribing (ORP) at initial credentialing and recredentialing.

The re-credentialing process also includes appraisal of the following data in its re-credentialing decision-making process for primary care practitioners:

- Member complaints and grievances, concerns, non-compliance with the program
    - Practitioner and organizational provider complaints are reviewed and resolved upon receipt by the Appeals and Grievances Department. When appropriate, complaints will be forwarded to the applicable Health Plan upon receipt.

- Information from quality improvement/utilization management activities

Upon receipt of the required re-credentialing information, the CHO and/or Credentials Committee will make recommendations as to the acceptance or rejection of provider applicants. Applicants will be formally notified within 60 days by letter of the determination.

In the event of Recredentialing documents not retuned timely an email will be submitted to the provider stating the following:

- If the application is not returned within the designated time period, you will be notified for a delinquent reappointment and will receive a (15) day extension to complete the paperwork.
- Failure to submit a reappointment application at least 45 days before the expiration date of the current appointment shall be deemed a voluntary resignation for Imperial Management Administrator Services and you will be submitted as "Inactive" to the Credentials Committee.
- Please do not hesitate to contact me directly if I can be of assistance in order to expedite this.
- Please ensure the CAQH is active and currently updated.

Behavioral Health Practitioners (California)

For California practitioners who provide service that treat mental health and substance abuse disorders whose contracts were issued, amended or renewed on or after January 1, 2023, IMAS will:

- Assess and verify the qualifications within 60 days after receiving the completed credentialing application; and
- Provide notification to the applicant within seven (7) business days of receipt of the application by the Credentialing Department to verify receipt and inform the applicant whether the application is complete.

Termination of Participating Physicians

The Committee is responsible for an objective assessment, discussion, and recommendation of the physician's status, taking into consideration all submitted re-credentialing information and the best interest of IMAS and the patients.

Procedures will be followed as defined in the IMAS Reduction, Suspension and Termination of Provider Policy (005). IMAS has an appeal process when the practitioner's participation with HP has been altered based on issues of quality of care and/or service. Refer to the IMAS Credentialing Fair Hearing Policy (002).

Health Delivery Organization Quality Assessment

A mechanism is in place to ensure that organizational providers are assessed prior to contracting and on a regular basis, every three years, thereafter. This process applies to acute care hospitals, home health agencies, skilled nursing facilities, freestanding surgical centers, rehabilitation facilities, psychiatric hospitals, labs, outpatient physical and speech therapy centers and renal dialysis centers, hospices, outpatient diabetics self-management training, portable x-ray supplier,

rural health clinics, federally qualified health centers and residential and ambulatory behavioral health facilities. These policies include meeting state and other regulatory requirements necessary for the entity accreditation status. Site visits are required if there is no accreditation status and the Credentialing Committee may recommend a site visit based upon their review of the information received when the required components have been met.

Upon receipt of the Health Delivery Organization (HDO) application, it is reviewed for completeness of the required documentation. All applications are completed within 60 days.

If the provider is not able to provide the components stated under entity requirements, the Credentialing Committee may use diligence in recommending approval based on information submitted and reviewed, and the need of the facility for patient care and limitation of other, existing comparable facilities.

For initial HDO credentialing and re-credentialing and ongoing monitoring and reporting of sanctions verifications shall be verified through Streamline Verify monthly via https://dmf.streamlineverify.com/search. The following websites are verified through Streamline Verify: Federal OIG, System Award Management (SAM), California Medi-Cal Suspended, Texas OIG, Medicare Opt-Out, & NPPES NPI Registry.

Standards:

A. Hospitals ***(which may include psychiatric services and outpatient services such as speech, physical and occupational therapies and dialysis etc. as defined under state licensure)***

- JCAHO/NCQA Accreditation
- State licensing
- Assigned Medicare number
- CLIA Certificate
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)
- QI Complaints

B. Skilled Nursing Facilities

- State Licensure
  Assigned Medicare number
- JCAHO/CCAC/CANHR/or Medicare survey accreditation
- CLIA Certificate
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)
- QI Complaints

C. Free Standing Surgical Center

- AAAHC/ JCAHO Accreditation/Medical Quality Commission
- State Licensure (If applicable)
- Assigned Medicare number
- CLIA Certificate
  General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)

- QI Complaints

D. Home Health

- State Licensure
- Assigned Medicare number
- JCAHO/ AAAHC/CHAP accreditation
- CLIA Certificate
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)
- QI Complaints

E. Rehab Facilities and/or Outpatient Physical and Speech Therapy Centers

- State Licensure
- Assigned Medicare number
- Appropriate Accrediting Entity
- CLIA Certificate
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)
- QI Complaints

F. Psychiatric Hospitals

- State Licensure
- Assigned Medicare number
- JCAHO/NCQA Accreditation
- CLIA Certificate
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)
- QI Complaints

G. Laboratories

- State Licensure
- Assigned Medicare number
- College of Pathologists Accreditation or other Appropriate Accreditation
- CUA Certificate or waiver
- CLIA Certificate
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)
- QI Complaints

H. End Stage Renal Disease Services

- State Licensure
- Assigned Medicare number
- CUA Certificate
- JCAHO /CMS/OHS Accreditation
- CLIA Certificate
- General Liability Insurance ($1M/$3M)

- Professional Liability Insurance ($1M/$3M)
- QI Complaints

I. Hospice

- State License
- Assigned Medicare Number
- JCAHO/ACHC Accreditation/Or other appropriate Accreditation
- CLIA Certificate
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)
- QI Complaints

J. Mobile X-Ray Supplier

- State License
- Assigned Medicare Number
- ACR Accreditation/Or other appropriate Accreditation
- CLIA Certificate
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)
- QI Complaints

K. Federally Qualified Health Center (FQHC)

- State License
- Assigned Medicare Number
- CLIA Certificate
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M)
- QI Complaints

L. Durable Medical Equipment

- State License
- Assigned Medicare Number
- Board of Certification/Accreditation/JCAHO/Other appropriate Accreditation
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M) (If applicable)
- QI Complaints

M. Residential and Ambulatory Behavioral Health Facilities

- State License
- Assigned Medicare Number
- JCAHO/Other appropriate Accreditation
- General Liability Insurance ($1M/$3M)
- Professional Liability Insurance ($1M/$3M) (If applicable)
- QI Complaints

Allied Health Professionals/Physician Extenders

At least every three years, the IMAS Credentials Committee confirms that the provider entity continues to be in good standing with the state and regulatory bodies. At the time of reassessment, the QI Department is requested to query their grievance tracking log for possible quality of care or service issues. The Credentials Committee reviews this information as part of the assessment process.

Allied health professionals are specially trained professionals, licensed by the State, who provide specialized health care services. This group includes psychologists, MFTs, and LCSWs. Allied health professionals contracted with IMAS will be expected to provide health care services within the scope of practice as defined by their State licensing body or professional association.

Minimum credentialing/re-credentialing requirements are as follows:

- Verification of state or professional license to practice within 180 days of Committee review
- Verification of Board Certification related to specialty within 180 days of Committee review
- Verification of current valid professional liability insurance within 180 days of Committee review
- Completed application which includes professional training, permission for release of information, attestation statement, release of information statement and professional references
- Work history of at least five years as demonstrated on application or CV
- Professional liability claims history of at least five years
- Sanction reports from NPDB or appropriate licensing agency

Completed re-credentials files will be reviewed and approved by the Credentials Committee. Allied health professionals have the same appeal rights and right to review information received during the Credentialing process as stated earlier in this document.

Physician Extenders are specially trained individuals who provide medical services under the supervision of their Physician supervisors.

Delegated Credentialing

IMAS is accountable for oversight and documentation of the Credentialing activities delegated to contractors. Delegation oversight will include:

- Pre-delegation audit of Credentialing policies and procedures (must comply with current NCQA criteria) and a file audit of initial and re-credentialing files according to the 8/30 rule.
- The credentialing activities which are delegated and for which the contractor is responsible.
- The reporting requirements of IMAS.
- The Program's continued approval of the delegated contractors credentialing program and activities.

The Credentials Committee has the right to approve new providers and to terminate or suspend individual providers. Additionally, IMAS must monitor the effectiveness of the credentialing and re-credentialing processes at least annually.

Program Evaluation

The Credentialing Program shall be evaluated and revised as necessary at least annually by the Credentialing Committee and the Board of Directors to ensure that it meets or exceeds established regulatory standards of credentialing and re-credentialing.

REFERENCES

- Applicable State and/or Federal regulations, Accreditation Standards, Contracted Health Plans
- California Bill AB 2581, CA HSC § 1374.197

ATTACHMENTS

None

IMPERIAL HEALTH HOLDINGS
MEDICAL GROUP

Policy and Procedure

Subject: Medi-Cal Provider Dispute Resolution	**Policy Manual:** Imperial Health Holdings Medical Group
Effective Date: May 1, 2016	**Policy Number(s):** 05-01-16-07-0017
Reviewed Dates: N/A	
Revision Dates: 04/14/2024	**Department: CLAIMS**
	Title: President/Chief Medical Officer/Medical Director
Last Revised by: N/A	**Approval Signature:** On File

SCOPE

Imperial Health Holdings Medical Group shall follow the procedures set forth in this policy.

This policy applies to the Medi-Cal line of business.

PURPOSE

To set forth the policy and procedure for processing all provider claims disputes.

POLICY

It is the policy of Imperial Health Holdings Medical Group to adhere to requirements specified in Sections 1300.71 and 1300.71.38, California Code of Regulations Title 28, Claims Settlement Practices and Dispute Resolution Mechanism, when processing provider claims disputes. Imperial Health Holdings Medical Group shall not impose a deadline for the receipt of a dispute that is less than 365 days from the last date of action.

PROCEDURE

1. Types of Provider Dispute Resolution (PDR) issues. Provider disputes that are submitted to Imperial Health Holdings Medical Group may contain requests to review the following types of issues:

    a. Claim payment or denial. Provider disputes payment or denial of claim for any reasons including timely submission, request for retroactive authorizations, eligibility, etc., are tracked through the PDR Database within the Claims Department.

b. Disagreement with request for overpayment. Provider disputes a request for reimbursement of an overpayment of a claim. The dispute is logged in the PDR database and acknowledged. The dispute is routed to Claims Revenue Recovery for research. Once it is finalized, it is returned to the Claims Specialist for the resolution letter.

c. Contract/DOFR interpretation disputes. When a provider dispute arises from a difference in understanding of a contractual interpretation, fee schedule or any term and condition of the contract, the dispute is reviewed and researched by the Claims Department and when research complete resolution letter is issued.

d. Denial of authorization for "pre-service" requests. When a pre-service dispute is received within the Claims Department, it is directed to the Network UM Department for review and retro-authorization determination. Once claim is received back from UM Department the Claims department issues a resolution letter.

2. Required submission of information. The provider must utilize the PDR Request Form a written notice that contains, at a minimum, the following information:
    a. Provider's name;
    b. Provider's identification number;
    c. Contract information; and
    d. A clear explanation of the disputed item, the date of service and a clear identification of the basis upon which the provider believes the payment amount, request for additional information, and request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect.

3. Receipt of claims. The Claims Mailroom Unit receives all Claims Department mail and is responsible for the sorting, batching, date stamping and inventory of all claim receipts.
4. Provider dispute must be acknowledged within 2 working days if submitted electronically or 15 working days if submitted in paper
5. IHHMG shall not impose a submission deadline of less than 365 days from action or in case of inaction, no less than 365 days after the time for contesting or denying a claim has expired
6. Resolution of Provider Dispute must be made in writing within 45 working days from the receipt of dispute
7. Whenever a payer contests, adjusts or denies a claim it shall inform the provider of the ability to dispute and include the procedure for obtaining forms, along with mailing address for submission of disputes

Initial Review

1. For paper claim disputes, the Claims department makes the initial determination of provider dispute(s) and sends acknowledgement letter(s) within fifteen (15) working days from date received. For electronic claim disputes an acknowledgement letter is sent within two (2) working days from date received.

2. If the Claims department determines that the submitted information is not a PDR, the information is forwarded to Claims Mailroom Unit for batching to Claims Examiners.

3. The Claims department enters the disputed information into the Imperial Health Holdings Medical Group Provider Web Portal. Information from Imperial Health Holdings Medical Group portal is automatically transferred to PDR Database.

4. The database automatically generates an acknowledgement letter based on the data entered above. Once this letter is issued, the data cannot be altered. Acknowledgment letters are sent the same day they are generated.
5. The Claims Specialist prints a tracking form that is generated by the database for each PDR submission. The tracking number is noted in the claims system history for cross-reference.

6. The Claim Specialist batches the PDRs by received date and enters received date and claims count into Inventory Control Database for inventory tracking.

Final Determination

7. The Claims department reviews PDRs based on oldest date on hand.

8. The Claims department reviews the details submitted by the provider to determine if Imperial Health Holdings Medical Group initial, decision should be overturned or upheld.

9. If a dispute is in favor of the provider, payment is issued to the provider within five (5) working days of determination. All applicable interest owed is included in the payment.

10. If additional information is required from a provider, a letter will be mailed to the provider requesting additional information within 45 days of receipt of the dispute. The PDR is held open for an additional 30 working days in order to receive requested information

11. The Claims department maintains all pended receipts and handles responses and non-responses from providers within the required time frame.

12. All final determinations are noted on the tracking form and if the Provider Dispute is overturned or upheld, a determination letter will be mailed to the provider within 45 working days from the date of receipt of the dispute

13. When batch of PDRs have been completed, the Claims department closes the inventory batch in Inventory Control Database.

PDR Database

1. The PDR Database is an internal device that tracks and stores all provider dispute information outside of the claims processing system. This Access database is used to compile and report details of the Provider Dispute Resolution Mechanism established by Imperial Health Holdings Medical Group.

2. All information entered is “backed up” for security purposes.

3. The database is “field” protected. PDR information entered in the database cannot be deleted or altered once it is saved.

4. Reports can be generated to review all data using the PDR Database**.** These reports are generated on the basis of open or closed disputes.

5. The Claims Manager generates reports for monitoring timely acknowledgements and timely completion of disputed receipts.

Note: *The Provider’s Right to Appeal is indicated at the bottom of every Imperial Health Holdings Medical Group’s Explanation of Payment (EOP) issued to a provider.*

Copies of provider disputes and the determinations, including all notes, documents and other information used to reach its decision, shall be retained for a period of not less than ten years.

Reference(s)

- AB1455
- 42 CFR 405.940, 405.942, 405.962, 405.944, 405.964§1852 (a)(2)(A)

Attachment(s)

None

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Imperial Management Administrative Services		**Policy and Procedure No:**	PNO:009
		Department:	Provider Network Management
Signature:	Provider Network Management	**Title:**	Provider Network Training
	Giuletta Rudon	**Effective Date:**	01/01/2023
Date:	01/30/2023	**Reviewed/Revised Date:**	03/01/2024

I. BACKGROUND

Imperial Health Holdings Medical Group ("IHHMG") through its delegate, Imperial Management Administrative Services, ("IMAS") shall follow the procedures set forth in this policy with respect to every contracted California network provider.

II. PURPOSE

To document the oversight process to ensure that all contracted network providers, understand the requirements of both federal and state law with respect to the delivery of medical care in California.

III. POLICY

Newly contracted providers will receive training on key public health linked programs and services available to patients, including program training requirements for participation in federally funded programs. IMAS shall also provide annual and recurring training to network providers on federally funded programs as well as California specific training programs.

Training may be completed by participation in IHHMG's sponsored training programs, a classroom setting, in-service, one-on-one training, or the distribution of training materials for self-review.

IMAS shall confirm that within ten days of placing a newly contracted provider on the IHHMG active roster that the provider understands and acknowledges that they

participated in the following orientation-training programs:

- California Children Services (CCS)
- California Coordinated Care Initiative Care Coordination Standards
- Child Health and Disability Program (CHDP)
- Cultural & Linguistics Training
- Cultural Competency and Disability Training
- Disability Literacy Training
- False Claims Act
- Fraud, Waste and Abuse
- Health Insurance Portability and Accountability Act (HIPAA) Training
- Interdisciplinary Care Team Training
- Initial Health Assessment/Health Risk Assessment
- Long Term Support Services
- New Provider Orientation Trainings
- Special Needs Plans (SNP) Model of Care Training

In addition, IMAS also provides initial and recurring training to network providers on the following:

- Provider Communications
- Enrollee Rights (including there will be no balance billing)
- Policies and Procedures
- Claims submission and payment.
- Identifying and reporting abuse, neglect, exploitation, and critical incidents
- Coordination of Benefits
- Special Needs Plans (SNP) Model of Care Training
- Fraud, Waste and Abuse
- Health Insurance Portability and Accountability Act (HIPAA) Training

IV. PROCEDURE

1.1. Within 10 days of placing a newly contracted provider on the IHHMG roster, IMAS will ensure that all network providers are trained where mandated by federal and California specific laws. The training documents will include an attestation whereby the network provider acknowledges that they've (i) reviewed the training material, (ii) understand the materials in which they reviewed and (iii) will comply in all respect with the requirements set forth therein, including all federal and California specific requirements in connection with the delivery and reporting of medical care while treating IHHMG's patients. The Provider Network Management Department will ensure the distribution of the individual plans for training materials, including required documentation and attestations for review.

1.2. Attached to the materials will be a coversheet to explain to the provider the requirement for review, participation, and compliance with the program. This document will also instruct the due date for completion and location to return the attestation.

1.3. The Provider Network Management Department will maintain distribution logs to document the date of distribution and the date the attestation is returned to IMAS.

1.4. Upon the receipt of the signed attestation verifying that the provider has completed the training materials, the Provider Network Management Department will inventory the attestation in the Provider Record for future reference and to determine when the following annual trainings must be executed in accordance with this Policy.

1.5. For any provider that does not return the attestation on time, a follow-up to the provider is made.

1.6. If the provider fails to return the training attestation, the provider will receive written notice and further instructions including compliance implications for failure to respond.

1.7. After written notice, if the provider continues to fail to return the attestation, the Provider Network Management Department Director shall report such non-compliance to the Quality Management Committee who will be required to take further action, which may include suspension or termination from the network.

2. Annual trainings will be calendared and performed within 12 months of the last training session.

3. Upon contracting, each provider's staff will be trained on the required training programs.

Sign-in sheets from on-site training will be maintained by the Provider Network Management.

IMPERIAL HEALTH HOLDINGS
MEDICAL GROUP

Policy and Procedure

Policy Name: Network Accessibility to Providers, access to appointments for PCP , Behavioral Health, Specialty Care.	**Policy#:** Access and availability
Line of Business: x **Medicare (CSNP/DSNP),** x **Medicaid,** ☐ **Commercial,** ☐ **Exchange**	
Effective Date:1/1/2024	**Revision Dates: 1/1/2024**
Department Name: Provider Network Management	
Department Leader: Giuletta Rudon	**Date:** 01/01/2024
Committee Approval:	**Date:**

DEFINITIONS:

Provider – Primary Care, Behavioral Health & Specialists
Standards – Guidelines approved by DMHC and CMS and NCQA to assess the accessibility of providers.

PURPOSE:

Refine Imperial Health Plan's (IHP) process to assess and mitigate the risk presented to our members by contracted providers within our network. Oversee the participating providers are offering members access to covered services in accordance with Imperial Health Plans Access to Care Standards and solicit their feedback and/or concerns through an annual provider survey.

POLICY:

This policy applies to Primary Care Physicians (PCP), Specialists (SCP), Behavioral/Mental (BH/MH) Healthcare Services, Ancillary and Dental Care Providers. Imperial will gather accurate demographic information on our providers. Survey IHP's provider network performance in themes of quality, patient experience, and disputes. Take corrective action to establish/meet the expectations of our providers.

Wait Times

- When a provider's office receives a call from an Imperial Health Plan member during regular business hours for assistance, the provider or other healthcare professional must either take the call within 30 seconds or call the member back within 30 minutes of the initial call.

- When an Imperial member calls a physician's office, hold time should not exceed 10 minutes.

- When and Imperial member arrives on time for an appointment, the member should be seen within 15 minutes of the scheduled appointment.

Follow-up of routine care for Behavioral Healthcare

Behavioral Health providers must have appointment availability to for routine follow-ups for members within 30 days, for non-prescribers within 20 days.

- Reasonable access data will be monitored through complaint data analysis.

Interpreter

Interpreter services must be coordinated with scheduled appointments for health care services to ensure availability at the time of appointment.

24/7 Access to Covered Services

Participating providers are responsible for offering Imperial Health Plan Members access to services covered 24/7. Access includes regular office hours on weekdays and the availability of a provider or other health care professional after regular office hours, on weekends and holidays. When unavailable, providers must arrange for on-call coverage by another participating provider. Providers are also required to meet appointment access standards as described below.

PROCEDURE:

Providers with highest volume are surveyed and evaluated first. Providers with lower membership will be surveyed secondarily using the access to appointments and after-hour care survey. (Attachment A).

After-hours call

- The answering service or after-hours personnel must ask the member if the call is an emergency. In the event of an emergency, the member must be immediately directed to dial **911** or to proceed directly to the nearest emergency room.

- If staff or answering services is not immediately available, an answering machine may be used. The answering machine or auto-attendant message must immediately direct the caller to dial **911** or go directly to the nearest emergency room. The message must also give members and alternative contact number or direct transfer or call back feature so they can reach the primary care physician (PCP) or on-call provider with a medical concerns or questions.

- Non-English-speaking members who call their PCP after hours should expect to get language-appropriate messages. In the event of an emergency, these messages should direct members to hand up and dial 911 or to proceed directly to the nearest emergency room.

- In non-emergency after-hours situations, members should receive instructions on how to contact the on-call provider.

- All calls taken by an answering service must be returned.

Monitoring

- Monitoring will be conducted via Provider Appointment Access Surveys at a minimum yearly occurrence and through patient surveys and complaints tracking.

- Results of monitoring and evaluation are communicated to staff and providers along with education as appropriate.

- Access standards must be 90% Compliant or above. If any of the Access Standards are found to be non-compliant the provider will be subject to increased monitoring and notified in writing with a request for a corrective Action Plan which must be submitted within 30 days of notification.

- Follow-up on the recommendation will be carries out as directed until issue(s) are resolved.

- Evaluations and corrective action reports will be gathered and reported to Provider Oversight's Quality Management Committee and the Governing Body.

Corrective Action

Imperial Health Plan (IHP) will carry out prompt investigation and corrective action when compliance monitoring determines the that (IHP) is not sufficient in ensuring patient access to care within the appropriate time frame, including but not restricted to taking all necessary and action were appropriate, to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance.

Imperial Health Plan shall give advanced written notice to all contracted providers affected by a corrective action who are deemed to be non-compliant by state, federal, NCQA access, and availability standards which will include:

- Clear descriptions of any identified deficiencies
- Coherent justification for the corrective action

- Provider shall be given the name and contact information of the authorized representative to respond to any concerns to regarding IHP's corrective action.

REGULATORY REFEERENCES:

MCM CHAPTER 4: SECTION 110

42 CFR 422.112

NCQA STANDARDS

POLICY ATTACHMENTS:

ATTACHMENT A – STANDARDS

Access to Care Standards for PCP's and SPC's

General Appointment	Standard
Emergency examination	Immediate access, 24/7 (Maybe directed to go to the emergency room or to hang up and call 911)
Access to non-urgent appointments with a primary care physician (PCP) for regular and routine primary care services	An appointment is offered within 10 business days from the time of the request.
Initial Health Assessment	For members 18 months of age and older, within 120 calendar days of enrollment
	For Medicare members, within 90 days of enrollment
Routine Prevention Exam	Within 30 calendar days of the request for an appointment
Access to urgent care services with a PCP that do not require prior authorization – (includes appointment with any physician, Nurse Practitioner, Physician's Assistant in office)	An appointment is offered within 48 hours from the time of the request. (96 hours for services that require prior authorization)

First Prenatal Visit	Within 14 calendar days of the request for an appointment
Access to after-hours care with a PCP	The ability for a member to contact an on-call physician after-hours; return call within 30 minutes for urgent issues
	PCP provides appropriate after-hours emergency instructions
Access to non-urgent care appointments with a specialist	An appointment is offered within 15 business days from the time of the request (after appropriate PCP visit)
Access to urgent care services that require prior authorization with a specialist or other provider	An appointment is offered within 96 hours from the time of the request
Access to urgent care with a Specialist	The specialist should see the member within 24 hours of receiving the request.
Routine Care with a Specialist	The specialist should see the member within 15 business days from date of request.
Telephone Access	Telephone access for screening and triage is available 24 hours a day 7 days a week. Answering machines or answering service must include a message the member that if they are dealing with a life-threatening emergency, they should seek immediate attention by calling 911 or going to the nearest emergency room.
Speed of Telephone Answer	The maximum length for a providers office staff to answer the phone is 30 seconds.
Medical Records	A copy of medical records and/or results of the visit should be sent to the PCP's office to allow continuity of care.
Shortening or Expanding Timeframes	Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally

	recognized standards of practice. If the timeframe is extended, it must be documented within the patient's medical record that a longer timeframe will not have a detrimental impact on the patient's health.
Non-urgent appointments for ancillary services for the diagnosis or treatment of an injury, illness, or other health condition	An appointment is offered within 15 business days from the time of the request
Missed Appointments	Missed appointment must be documented in the medical record the day the missed appointment the members bust be contacted my mail or phone to reschedule win 48 hours.

Behavioral Health Access to Care Standards

Criteria	Standard
Life threatening/Emergency needs	Will be seen immediately
Non-Life-threatening emergency needs	Will be seen within 6 hours

Urgent needs exam	Within 48 hours
Routine office visit, non-urgent exam	Within ten 10 Business Days
Non-Physician Behavioral Health Provider: Routing office visit, non-urgent exam	Within ten 10 Business Days
After-hours care	Available 24 hours a day, 7days a week.
Telephone Access	Telephone access for screening and triage is available 24 hours a day 7 days a week. Answering machines or answering service must include a message the member that if they are dealing with a life-threatening emergency, they should seek immediate attention by calling 911 or going to the nearest emergency room.
Speed of Telephone Answer	The maximum length for a practitioner's office staff to answer the phone is 30 seconds.
Standard for reaching a behavioral health professional	Imperial Health Plan through our contracted behavioral health providers is available to arrange immediate access to a behavior health professional.

Criteria	Standard
Skilled Nursing Facility	Skilled Nursing Facility services will be available within 5 business days of request
Intermediate Care Facility/Developmentally Disables (ICF-DD)	ICF-DD services will be available within 5 business days or request. (These services are provided by Skilled Nursing Facilities and Nursing Facilities where 24 hour nursing services are provided. `
Community Based Adult Services (CBAS)	Meeting appointment time requirements based upon the population density of counties serviced within the required wait times for appointment

POLICY ATTACHMENTS:

IMPERIAL HEALTH HOLDINGS
MEDICAL GROUP

Policy and Procedure

Policy Name: Provider Panel Updates	**Policy#:**
Line of Business: [x]Medicare (CSNP/DSNP), [x] Medicaid, [x] Commercial, [ ]Exchange	
Effective Date: 01/01/2024	**Revision Dates:**
Department Name: Provider Data Manegement	
Department Leader: Kristine Agbuya	**Date: 04/01/2024**
Committee Approval:	**Date:**

PURPOSE:

TO ENSURE PROVIDER INFORMATION, INCLUDING DEMOGRAPHICS, IS BEING MANAGED AND UPDATED AS NEEDED BY THE PROVIDER DATA MANAGEMENT DEPARTMENT.

POLICY:

IMAS POLICY IS TO ENSURE THAT DATE INTEGRITY OF PROVIDER RECORDS ARE MAINTAINED ACCURATELY IN EZCAP

PROCEDURE:

1. PDM receives notification from Incidents, PNM, Medical Group or IPA to close or open provider panels.

2. The PDM Coordinator will review the supporting documentation or notification for the provider/group/vendor to update panels.

    a. Close or open panels for a specific Line of Business

    b. Close or open panels for a specific Company ID

    c. Provide the effective date for the updated panels.

3. If the attached supporting documentation or notification is not sufficient to close or open panels, PDM will inform the party and request additional information.

4. If the attached supporting documentation is sufficient, the PDM Coordinator will add a panel date to the provider(s) for the group.

5. A new contract status of Closed Panels “CP” for PCPs and “SP” for specialists will be added to the provider(s) for the group with a new effective date of when the provider’s panels were closed.

6. A memo for the closed panels will be added to the provider notes – “Closed Panels”. The subject of the body will include the date of notification to close panels, or incident number.

7. If the panels are currently closed and need to be PDM will be updated to an open contract statu.

8. A memo for the opened panels will be added to the provider notes – “Opened Panels”. The subject of the body will include the date of notification to open panels, or incident number.

9. The PDM Coordinator will upload the supporting documentation into the provider record.

10. The PDM Coordinator will notify PNM/PNA or group once the provider’s panels are updated.

REGULATORY REFERENCES:

<examples CMS, DHCS, NCQA>

POLICY ATTACHMENTS:

Policy and Procedure IMPERIAL HEALTH HOLDINGS MEDICAL GROUP

Policy Name: PNM Provider Verification Calls	**Policy#: GR090123**
Line of Business: ☒Medicare (CSNP/DSNP), ☒ Medicaid, ☒ Commercial, ☒ Exchange	
Effective Date: 09/01/2023	**Revision Dates: 01/01/2024**
Department Name: Provider Network Management	
Department Leader: Giuletta Rudon	**Date: 09/01/2023**
Committee Approval:	**Date:**

PURPOSE:

To create a process to ensure that Provider Verifications are performed in accordance with the requirements for MAOs and participating IPAs. Provider Verifications are also performed to validate & verify all of the providers demographics and maintain communication with providers.

POLICY:

The Provider Network Management Department has established a policy to outline the process for Provider Verifications to the contracted network to maintain data accuracy of the Provider Directory.

PROCEDURE:

Provider Verifications:

1. PNM will conduct thorough Provider Verifications daily through telephone and face to face visits to each provider.
2. The verification process will encompass cross-referencing provider demographical information including names, specialties, National Provider Identifiers (NPIs), contact details, practice locations, appointment availability and office contact and document attempt on EZCAP.
3. Follow up provider verification for Primary Care Physicians are every 60 days, whereas Specialists, Ancillary, DME, & Hospitals are contacted every 90 days. Each time that a verification via face to face or telephone call to the provider, PNA's must conduct verification of all current information as recorded in the Provider Directory. PNA assists to report and correct discrepancies identified by the provider.
4. All provider verification calls and/or site visits must be documented in EZ Cap. Documentation must consist of PNA's name, the name of the staff member at the provider's office that verified contact details, and practice location. In addition, the office point of contact and email address or fax number is also required to be documented. Documentation must specify if the provider is accepting new patients and the next available new patient appointment.

Provider Verification Corrections:

1. In cases where providers are identified as having data inconsistencies or inaccuracies during the verification, the respective PNA will be responsible for initiating corrective actions.
2. The PNA will document their outreach efforts to the identified provider through various communication channels, including telephone calls, emails, fax, and mailed notices in EZ Cap with the date the discrepancy was identified.
3. Documentation in EZ Cap of all outreach attempts and responses will be maintained for audit purposes.

Provider Information Update:

1. Upon notification of discrepancies, PNM will promptly update the provider's information, so the information is reflected correctly in the Provider Directory.
2. PNM will maintain clear documentation of discrepancies regarding the provider and the subsequent update to the Provider Directory.

Continuous Improvement:

1. PNM will communicate with the provider's office via email or fax, proceeding with the provider contact, as a follow-up, to increase communication, effectiveness, efficiency and to strengthen a professional relationship.

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Pregnancy Care Guidelines	
Policy Number(s): 10-019	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP, and Specialist shall follow the procedures set forth in this policy.

PURPOSE

Policies and Procedures to ensure the provision of all Medically Necessary services for pregnant using the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum of quality of prenatal services.

POLICY

IHHMG will implement a comprehensive risk assessment tool for all pregnant female members that is comparable to the ACOG standard and Comprehensive Perinatal Services Program (CPSP) standards per Title 22, CCR, Section 51348.

The results of this assessment shall be maintained as part of the obstetrical records and shall include medical/obstetrical, nutritional, psychosocial and health education needs risk assessment components.

PROCEDURE

1. Referral to Specialists: IHHMG shall ensure that pregnant women at high risk of a poor pregnancy outcome are referred to appropriate specialists including perinatologists andhave access to genetic screening with appropriate referrals.
2. The IPA ensures that pregnant members are offered pregnancy services in

theComprehensive Perinatal Services Program (CPSP)

3. In the event the member refuses the CPSP program. The refusal shall be documented inthe member's medical record.

Reference(s)
Policy: Comprehensive Perinatal Services Program CPSP #05-01-16-05-004

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure

Utilization Management Department

Policy Title: Prior Authorization Process – Including Extensions	
Policy Number(s): 05-101	**Orig. Date:** 05/01/16
Effective: 10/07/22	**Revision(s) Date:** 06/25/17, 09/01/19, 11/15/20, 12/01/20, 07/19/21, 11/10/21, 02/01/22, 10/07/22, 03/28/24
MSC Committee Approval: **Date: 03/28/24** 	**Department:** UTILIZATION MANAGEMENT
	VP/Director Approval: **Date:**
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT ☒ HCMG ☒ LSMG	**SCOPE: UM**

SCOPE
Imperial Health Plan, Imperial Insurance Companies, Imperial Health Holdings Medical Group, HealthCosmos Medical Group, and LoneStar Medical Group shall follow the procedures set forth in this policy.

PURPOSE
To provide a mechanism for reviewing selected medical treatment/services to assure appropriate utilization.

POLICY

Providers shall obtain authorization for all services that are NOT listed on the ***Direct Referral Form*** **(**Attachment A) prior to delivering those services.

The Utilization Management (UM) Department has the capability to receive the request via fax, written requests, provider portal, or orally for both standard and expedited preservice determinations and can accept requests from members or providers.

All requests, including oral transcription, are documented and maintained in case specific files within the prior authorization application.

Providers shall determine member eligibility, benefit coverage, medical appropriateness, necessity and level of care prior to submitting the request. Providers shall be notified in writing, at time of contracting, of the services that require prior authorization and shall be provided with all relevant forms. Any updates to the *Direct Referral Form* shall be communicated in writing to all contracted providers and affected departments at least 30 days prior to any changes.

PROCEDURE

1. The Prior Authorization Utilization Management Coordinator (UMC) receives standard and expedited requests for prospective, concurrent, and retrospective services through the following channels:
   1.1. Physicians, both contracted and non-contracted, submit requests through the fax, hard copy, provider portal, or orally.
   1.2. Physicians submit hard copy requests on a standardized prior authorization request form.
   1.3. Physicians or members may request a service orally.
   1.4. Members and their authorized representatives may also request prior authorization for services.
2. Each request is date and time stamped when received.
3. The requesting Physician submits timely prior authorization requests with the required information for processing, such as member information and medical necessity documentation. The physician indicates whether the request is standard or expedited based on the urgency of the service.
4. The UMC receives the prior authorization request and verifies eligibility, benefits, and required information for processing. This includes the member name, address and telephone number, member ID number, diagnosis codes (ICD-9/10) for all applicable diagnoses, requested service codes (CPT) for all applicable services, requested provider, Primary Care Physician or Specialist name and his/her Tax Identification Number (TIN), telephone and fax numbers and clinical support information to use in application of criteria.
   4.1. If the member is not eligible, the UMC contacts the referring provider and directs them to contact the member for clarification of coverage / assigned PCP.
   4.2. If the member does not have the benefit, the UMC forwards it to the RN / LVN (Nurse) who will discuss with the Medical Director and generate a Benefit Denial Letter.
5. The UMC data enters Fax and oral Requests into the prior authorization application. S/he checks the prior authorization request for receipt of all necessary information. If clinical information is incomplete, outreach is performed and the referring source is contacted for the missing required information.
6. The UMC gathers relevant clinical information to support nonbehavioral healthcare UM decision making. Requests for Behavioral Health are directed to the carved out Behavioral Health Organization.
   6.1. The organization, when conducting routine prior authorization review, concurrent review, or retrospective review will:
      6.1.1. Accept information from any reasonably reliable source that will assist in the authorization process
      6.1.2. Collect only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services
      6.1.3. Not routinely require hospitals, physicians, and other providers to numerically code diagnoses or procedures to be considered for authorization, but may request such codes, if available
      6.1.4. Not routinely request copies of all medical records on all patients reviewed
      6.1.5. Require only the section(s) of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service, or length of anticipated inability to return to work
      6.1.6. Administer a process to share all clinical and demographic information on individual patients among its various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from members or providers.
7. If the clinical information can be obtained over the telephone, the UMC transfers the call to a Nurse to take a telephone order and document the information online with his/her initials as a valid signature. The Nurse must indicate to the requesting physician, at the time of the call, that s/he is responsible for sending in the supporting documentation the same day.

8. If the plan does not receive any additional information, the plan will make the best decision it can based on the information available within the required adjudication timeframes.

Methods for requesting information should vary depending on the type of request and the adjudication timeframe. Outreach methods can include:

- Telephone;
- Fax;
- E-mail; and/or
- Standard or overnight mail with certified return receipt.
- For Commercial urgent concurrent decisions, voicemails are not an acceptable form of oral notification.

Best Practice for Medicare Advantage Organizations for Outreach

	Adjudication Timeframe	Number of Outreach Attempts	Timing of Outreach Attempts
Standard Org Determination- Pre-Service	14 days	3	*Initial attempt within 2 calendar days of request *When possible, during business hours in the providers time zone
Expedited Org Determinations	72 hours	3	*Initial attempt upon receipt of request, must request within 24 hours of receipt *When possible, during business hours in providers time zone

Processing Turnaround Times
See appendices for timeliness standards.

Processing requests

9. The UMC forwards the request to the Nurse's queue no later than one working day of receipt, or as expeditiously as the member's health requires.
10. The Nurse reviews the prior authorization requests in the order received except for expedited requests which are given priority and reviewed the same date of receipt.
11. The UM Manager reviews pended cases throughout the day and at the close of business. S/he will reprioritize the Nurse's case load as necessary.
12. The organization ensures that the frequency of reviews for the extension of initial determinations is based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity (i.e., not routinely conducted on a daily basis).
13. For prior authorization and concurrent review, IHHMG bases review determinations solely on the medical information obtained by the organization at the time of the review determination
14. For ongoing care, reductions or terminations in a previously approved course of treatment, the organization issues the determination early enough to allow the patient to request a review and receive a decision before the reduction or termination occurs.
15. If the referral request lacks the information necessary to establish medical necessity, the Nurse

faxes a request for more information to the referring source specifying the information needed and documents actions in the UM system.

15.1. Clinical information to be obtained must include at a minimum

15.1.1. History of presenting problem, clinical exam

15.1.1.1. Findings, diagnostic testing results, treatment progress notes, psychosocial history, information on

15.1.1.2. Consultations with the treating practitioner, evaluations from other health care practitioners and providers, photographs, operative and pathological reports, rehab evaluations, printed copy of criteria related to the request, information regarding benefits for services or procedures,

15.1.1.3. Information regarding the local delivery system, info from patient and responsible family members.

16. If the referring source classified the referral as expedited and the Medical Director needs additional information in order to establish medical necessity for expediting the case, the Nurse pends the request and if necessary, initiate the 14 Days extension letter and transfer to the UMC, who maintains a log of such letters and sends it to member via regular U.S. mail. The notification informs the member of his/her right to file an expedited grievance if he/she disagrees with the decision to grant the extension. The UMC documents his/her actions related to the extension online.
17. If the case does not meet criteria for sending the 14 Days extension letter, the Nurse shall submit the case to the Medical Director for a determination.
18. The member will be notified of the decision via the specific CMS approved Health Plan Templates.
19. The notification informs the member of his/her right to file an expedited grievance if s/he disagrees with the decision not to expedite. The Medical Director and Nurse document their actions related to the decision in the UM system.
20. If the referring source classified the referral as standard and the Medical Director needs additional information in order to establish medical necessity, the Nurse will request additional information. If the information is not received by the 12th day, the nurse will pend the request and initiate the 14 Days extension letter and transfer to the UMC, who maintains a log of such letters and sends it to the member via regular US mail.
21. If extended, the decision is required within a maximum of 28 calendar days after receipt of request.

21.1. **NOTE:** Extension allowed only if member requests or the organization justifies a need for additional information and how the delay is in the interest of the member. (For example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny).

22. The notification informs the member of his/her right to file an expedited grievance if s/he disagrees with the decision to grant the extension. The UMC documents his/her actions related to the extension online.
23. If the referring physician fails to provide medical necessity support information to complete the request, the case is submitted to the Medical Director for determination within seven (7) business days.
24. The Medical Director reviews any incomplete request and determines whether to approve as requested, pend for lack of information or documentation, or deny for medical necessity.
25. If the IHHMG cannot make a determination for non-urgent prospective or continued stay reviews within the required time frame due to not received all of the requested necessary information, IHHMG will Immediately notify the health care provider and the covered person in writing

25.1. Send notification upon the expiration of the required give (5) business day time frame OR as soon as IHHMG becomes aware that we will not be able to meet the required five (5) business day time frame, whichever occurs first, the anticipated date on which a prospective or continued stay review determination may be rendered

25.1.1.1. Notification will specify the information required, but not received

26. Upon receipt of all necessary information, IHMG will render a prospective or continued stay review determination within the required five (5) business day time frames
27. If a contracted physician continually fails to provide complete member information or necessary documentation in order to establish medical necessity, the Nurse refers the issue to the Provider Services/Contracting Director so that further provider education can take place.
28. The Nurse reviews the request, applies criteria, and documents prior authorization requests.
    - 28.1. Determinations will result in one of the following:
        - 28.1.1. Approve request if it meets criteria or
        - 28.1.2. Submit the request to the Medical Director when criteria are not met
        - 28.1.3. The Medical Director reviews request when requested services do not meet established medical necessity, or benefit coverage guidelines, or are considered experimental or investigational or the request if out-of-network
            - 28.1.3.1. If the request is experimental or investigational, including clinical trials, it will be immediately referred to the health plan for initial determination, regardless of benefit exclusion
        - 28.1.4. The Medical Director may confer with Board Certified Specialty Consultants in the related specialty and discuss the case with the requesting physician before making the determination. Determinations results in one of the following:
            - 28.1.4.1. Approve, as requested;
            - 28.1.4.2. Deny for lack of medical necessity; or
            - 28.1.4.3. Deny as modified, if only a portion of the request was approved
            - 28.1.4.4. Deny because the service is not a covered benefit
    - 28.2. The Medical Director documents his/her decision in the UM system and submits the case to the Nurse to make changes to the status field to approve or deny based upon his / her direction.
        - 28.2.1. In cases where a favorable determination takes place for any of the following procedures, the Nurse or assigned staff first confirms that the facility that is being authorized is a Medicare Certified facility to perform the specified procedure. This can be validated at the CMS website: www.cms.gov/MedicareApprovedFacilitie/BSF/list.asp
            - 28.2.1.1. Carotid artery stenting
            - 28.2.1.2. Certain oncologic PET scans in Medicare-specified studies
            - 28.2.1.3. Lung-volume reduction surgery
            - 28.2.1.4. Ventricular assist device (VAD) destination therapy

29. During the course of reviewing the case, the Medical Director, the Nurse, or the UMC may make a recommendation for the referral of member to appropriate service including case management of pregnant member, member in need of behavioral health services, care coordination case management, disease management, or refer members with high ER utilization for case management.
    29.1. Some services may be immediately referred, others may require coordinating with the Primary Care Provider,

DEFERRED Process/Procedure (Only for Commercial\Medical LOB)

Process:

If a decision will be deferred for lack of clinical information needed to make a determination, a **Deferral Letter** is to be sent out. CA Health & Safety Code 1367.01 SB 59

- Commercial Time frame: if decision can't be made within 5 working days, the member & practitioner must be notified of the deferral in writing within 5 working days of receipt of request

& allow 45 calendar days from the date of deferral for submission of requested information (a decision to deny requested service cannot be made before the 45th calendar day from day of deferral unless clinical information is received prior to the 45th day)

- Medi-Cal Time frame: if decision can't be made within 5 working days, the member & practitioner must be notified of the deferral in writing within 5 working days of receipt of request & allow 14 calendar days from the date of receipt of the original request for submission of requested information (a decision to deny requested service cannot be made before the 14th calendar day from day of receipt of original request unless clinical information is received prior to the 14th day)
- Follow-up notification: Practitioner must be notified within 24 hours of making the decision and a written, electronic notification of denial and modification to practitioner and member.
- Mechanism to track, and Reason for pending.
    - Examples of reason for pending a request may include:
        - Additional information is needed before physician reviewer can make an appropriate decision;
        - or Benefit clarification is needed.

Dismissal or Withdrawal

A request for an initial determination be withdrawn at any time before the decision is issued. This request must come from the party who requested the initial determination. The request to withdraw may be either written or verbal. A provider may cancel or withdraw a referral request in writing or by telephone stating the reason for the cancellation request. If a request to withdraw is filed with the plan, the plan will dismiss the initial determination request.

Acceptable reasons are:

- The member changed their mind
- The provider wishes to change the request to a different specialty, provider or facility.
- The member has termed with IHHMG or the Health Plan
- The request was a duplicate
- The original request has expired.

A withdrawal must not interrupt, withhold or delay patient care or result in underutilization of healthcare services.

The staff member changes the status in the prior authorization system to “Cancel”. The UM system has reporting capabilities to filter and track cancelled referral requests according to the member’s health plan.

1. The clinical staff will review all withdrawal requests against the cancelation criteria.
2. When/if the request meets the criteria, the clinical staff will cancel the referral in the UM system
3. Reason for withdrawal with be documented in external notes.
4. The requesting provider and the member will be notified of the withdrawal/dismissal
5. If the referral was to have been sent to referred to provider/vendor, that provider will be notified within the same time frame.

Termination, Suspensions, or Reductions For Medi-Cal Health Plans Only

For terminations, suspensions, or reductions of previously authorized services, MCPs must notify members at least ten days prior to the date of the action pursuant to Title 42 CFR

section 431.211 to ensure there is adequate time for members to timely file for Aid Paid Pending, with the exception of circumstances permitted under Title 42 CFR sections 431.213 and 431.214.

Standing Specialist Referrals Including HIV/AIDs

1. A member, who requires specialized care over a prolonged period for a life-threatening, degenerative or disabling condition, including Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), may be allowed a standing referral to a specialist who has expertise in treating the condition or disease for the purpose of having the specialist coordinate the members healthcare.
2. 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 Provider Organization will refer the member to an HIV/AIDS specialist who meets California Health and Safety Code criteria.
3. The PCP, specialist and designated physician determines that continuing care from a specialist is needed and referrals are made based on an agreed upon treatment plan, if any. Treatment plans may limit the number of specialist visits or the length of time the visits are authorized, and may require the specialist to make regular reports to the PCP.
4. After receiving standing referral approval, the specialist is authorized to provide healthcare services that are within the specialists area of expertise and training to the member in the same manner as the PCP.
5. Decisions will be made within the time frames appropriate to the condition of the member (e.g., urgent, non-urgent, concurrent), not to exceed 3 business days of the date that all necessary information is received.
6. If authorized, the actual referral (notification) will be made within 4 business days of the date and the proposed treatment plan, if any, is submitted to the designated physician (e.g., Medical Director).
7. If a network specialty provider is not available to see the member within the access timeframes, there is a process for arranging specialty care outside of the network.
    - 7.1. The UM Nurse discusses the case with the Medical Director and reaches out to a non-contracted provider to make the referral. The non-contracted provider shall be within the same geographic area.
    - 7.2. The UM Nurse will ask the provider if s/he will accept Medicare / Medi-Cal FFS rates. If s/he agrees, the Nurse shall contact Provider Contacting to obtain a Letter of Agreement
    - 7.3. In cases where an Adverse Determination takes place refer to the Adverse Determinations Policy & Procedure

Prior-Authorization processing is tracked through the online reports:

- Authorization turnaround times;
- Percentage authorization category;
- Favorable Determinations
- Adverse Determinations
- Extensions
- Appeals
- Nurse productivity
- UMC productivity
- Unused/Expired Authorization (MCL)

The Manager of UM monitors' online system reports in order to ensure compliance with timeframes – See Appendix

If procedures are not adhered to, the Manager of UM develops a corrective action plan as necessary in order to ensure compliance with policies and procedures.

Medi-Cal Member Transition from FFS to Medical Managed Care Plan (MMCP)

Members that transition into a MMCP, have the right to request Out of Network (OON) and Continuity of Care (COC) in accordance with State law and health plan requirements.

The Programs include:

- Low Income Health Program (LIHP)
- Medical Exemption Request (MER)
- Seniors & Persons with Disabilities (SPD)
- Other Targeted Low Income Children (OTLIC) Continued access is permitted for care for up to 12 months
-

OON and COC requests are processed within five (5) working days of receipt of request and must be completed within thirty (30) calendar days. When the medical condition requires more immediate attention, the organization follows ICE Medi-Cal TAT Standards.

Submission of quarterly reports to the health plan are required based upon contractual terms.

Beneficiary protections related to plan-directed care, CMS chapter 4 section- 160:

A member, or a provider acting on behalf of the member, always has the right to request a pre-service organization determination if there is a question as to whether an item or service will be covered by the plan. If the plan denies an enrollee's (or his/her treating provider's) request for coverage as part of the organization determination process, the plan must provide the enrollee (and provider, as appropriate) with the standardized denial notice (Notice of Denial of Medical Coverage (or Payment)/CMS- 10003).

Reference(s)

42 CFR422.204(b)(1) and (3);
42 CFR §§ 431.211, 431.213 and 431.214
42 CFR §§ 422.566, 422.568, 422.570, 422.572

MA-14 Element F

NCQA UM 1, NCQA UM 6 QA UM 13 A QI 7, QI 8)

CMS MANUAL CHAPTER 4 SECTION 150, 160
State Contract; standards used based on state contract if more stringent
29 CFR 2560.503-1(b)(1)(f)(2)(i); 29 CFR 2560.503-1(b)(1)(f)(2)(iii)(A);
CA Health & Safety Code 1367.01 (h)(5)

Appendices

Utilization Management Timeliness Standards, (Medi-Cal Managed Care - California)

Utilization Management Timeliness Standards, Centers for Medicare and Medicaid Services (CMS)

Utilization Management Timeliness Standards, (Commercial HMO - California)

Attachment(s)
ATT A – Medi-Cal TAT ATT B – Commercial TAT

Direct Referring Services Form

Direct Access Referral form (Auto

Request for Clinical Information Fax Cover Sheet

Need Clinical Info Fax Cover Sheet.docx

Best Practices for Conducting Outreach for Medicare Advantage Organizations

Outreach.docx

Utilization Management Timeliness Standards
(Medi-Cal Managed Care - California)

		Notification Timeframe Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s)	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Routine (Non-urgent) Pre-Service All necessary information received at time of initial request	Within 5 working days of receipt of all information reasonably necessary to render a decision	Practitioner: Within 24 hours of the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service
Routine (Non-urgent) Pre-Service **– Extension Needed** • Additional clinical information required • Require consultation by an Expert Reviewer • Additional examination or tests to be performed (AKA: Deferral)	Within 5 working days from receipt of the information reasonably necessary to render a decision but no longer than 14 calendar days from the receipt of the request • The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Health Plan/ Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest • Notify member and practitioner of decision to defer, in writing, within 5 working days of receipt of request & provide 14 calendar days from the date of receipt of the original request for submission of requested information. Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or		

		Notification Timeframe Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s)	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
	tests required and the anticipated date on which a decision will be rendered **Additional information received** • If requested information is received, decision must be made within 5 working days of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service **Additional information incomplete or not received** • If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial	Practitioner: Within 24 hours of making the decision Member: None Specified Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service
Expedited Authorization (Pre-Service) • Requests where provider indicates or the Provider Group / Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. • All necessary information	Within 72 hours of receipt of the request	Practitioner: Within 24 hours of making the decision Member: None specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 3 working days from the receipt of the request for service

		Notification Timeframe Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s)	
Type of Request	**Decision**	**Initial Notification** **(Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of <u>Denial and Modification</u> to Practitioner and Member**
received at time of initial request			
Expedited Authorization (Pre-Service) - Extension Needed • Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. • Additional clinical information required	**Additional clinical information required:** Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify practitioner and member using the "delay" form, and insert specifics about what has not been received, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered • Note: The time limit may be extended by up to 14 calendar days if the Member requests an extension, or if the Provider Group / Health Plan can provide justification upon request by the State for the need for additional information and how it is in the Member's interest **Additional information received** • If requested information <u>is received</u>, decision must be made within 1 working day of receipt of information. **Additional information incomplete or not received** • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.	<u>Practitioner</u>: Within 24 hours of making the decision <u>Member</u>: None specified <u>Practitioner</u>: Within 24 hours of making the decision <u>Member</u>: None specified	<u>Practitioner</u>: Within 2 working days of making the decision <u>Member</u>: Within 2 working days of making the decision <u>Practitioner</u>: Within 2 working days of making the decision <u>Member</u>:

		Notification Timeframe Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s)	
Type of Request	**Decision**	**Initial Notification** **(Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
			Within 2 working days of making the decision
Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulatory services) In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. **CA H&SC 1367.01 (h)(3)**	Within 5 working days or less, consistent with urgency of Member's medical condition **NOTE:** When the enrollee's condition is such that the enrollee 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 the normal timeframe for the decision-making process… would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination **CA H&SC 1367.01 (h)(2)**	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision
Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulatory services) **OPTIONAL:** Health Plans that are NCQA accredited for Medi-Cal may chose to adhere to the more stringent NCQA standard for concurrent review as outlined.	Within 24 hours of receipt of the request	Practitioner: Within 24 hours of receipt of the request (for approvals and denials) Member: Within 24 hours of receipt of the request (for approval decisions)	Member & Practitioner: Within 24 hours of receipt of the request **Note:** If oral notification is given within 24 hour of request, then written/electronic notification must be given no later than 3 calendar days after the oral notification

		Notification Timeframe Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s)	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days from receipt or request	Member & Practitioner: None specified	Member & Practitioner: Within 30 calendar days of receipt of the request
Post-Service - Extension Needed Additional clinical information required	**Additional clinical information required (AKA: deferral)** • Decision to defer must be made as soon as the Plan is aware that additional information is required to render a decision but no more than 30 days from the receipt of the request		
	Additional information received • If requested information is received, decision must be made within 30 calendar days of receipt of information • Example: Total of X + 30 where X = number of days it takes to receive requested information	Member & Practitioner: None specified	Member & Practitioner: Within 30 calendar days from receipt of the information necessary to make the determination
	Additional information incomplete or not received • If information requested is incomplete or not received, decision must be made with the information that is available by the end of the 30th calendar day given to provide the information	Member & Practitioner: None Required	Member & Practitioner: Within 30 calendar days from receipt of the information necessary to make the determination

		Notification Timeframe Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s)	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Hospice - Inpatient Care	Within 24 hours of receipt of request	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision

Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

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

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

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

Type of Request	Decision	Notification Timeframes
	additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions must not be used to pend organization determinations while waiting for medical records from contracted providers. When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request). Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	▪ Give notice in writing, within 72 hours of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. Note: The Health Plan must respond to an expedited grievance within 24 hours of receipt. Decision Notification After an Extension: ▪ Approvals – Oral or written notice must be given to member and provider no later than upon expiration of extension. – Document date and time oral notice is given. – If written notice only is given, it must be received by member and provider no later than upon expiration of the extension. ▪ Denials – When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be received by member and provider no later than upon expiration of extension. – Use NDMC template for written notification of a denial decision.

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
Hospital Discharge Appeal Notices (Concurrent)	Attending physician must concur with discharge decision from inpatient hospital to any other level of care or care setting. Continue coverage of inpatient care until	Hospitals must issue the IM within 2 calendar days of admission, obtain the signature of the member or representative and provide a copy of the IM at that time. Hospitals must issue a follow up IM not more than 2 calendar days prior	Upon notification by the QIO that a member or representative has requested an appeal, the Health Plan or delegate must issue the DND to both the member and QIO as soon as possible

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

Type of Request	Decision	Notice of Medicare Non-Coverage (NOMNC) Notification	Detailed Explanation of Non-Coverage (DENC) Notification
Termination of Provider Services: ▪ **Skilled Nursing Facility (SNF)**	The Health Plan or delegate is responsible for making the decision to end services no later than two	The SNF, HHA or CORF is responsible for delivery of the NOMNC to the member or authorized representative	Upon notification by the Quality Improvement Organization (QIO) that a member or authorized

▪ **Home Health Agency (HHA)** ▪ **Comprehensive Outpatient Rehabilitation Facility (CORF)** NOTE: This process does not apply to SNF Exhaustion of Benefits (100 day limit).	(2) calendar days or 2 visits before coverage ends: ▪ Discharge from SNF, HHA or CORF services **OR** ▪ A determination that such services are no longer medically necessary	▪ The NOMNC must be delivered no later than 2 calendar days or 2 visits prior to the proposed termination of services and must include: member name, delivery date, date that coverage of services ends, and QIO contact information. ▪ The NOMNC may be delivered earlier if the date that coverage will end is known. ▪ If expected length of stay or service is 2 days or less, give notice on admission. **Note**: Check with Health Plan or delegate for delegated responsibility, as a Health Plan or delegate may choose to deliver the NOMNC instead of the provider.	representative has requested an appeal: ▪ The Health Plan or delegate must issue the DENC to both the QIO and member no later than close of business of the day the QIO notifies the Health Plan of the appeal.
Part Band C Prescription Drugs	▪ **Standard:** Within 72 hours of receipt of request ▪ **Expedited:** Within 24 hours of receipt of request	▪ **Standard:** Within 72 hours of receipt of request ▪ **Expedited:** Within 24 hours of receipt of request	**Standard:** Within 72 hours after receipt of request. • Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision **Expedited:** **<u>Approvals</u>** ▪ Oral or written notice must be given to member and provider within 24 hours of receipt of request. ▪ Document date and time oral notice is given. ▪ If written notice only is given, it must be received by member and provider within3 calendar days of receipt of request. **<u>Denials</u>** ▪ Oral or written notice must be given to member and provider within 24 hours of receipt of request.

			▪ When oral notice is given, it must occur within 24 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. ▪ Document date and time of oral notice. ▪ If only written notice is given, it must be received by member and provider within 24 hours of receipt of request. ▪ Use NDMC template for written notification of a denial decision.
Part D Prescription Drugs (only)	▪ **Within 24 hours of receipt of request**	▪ Within 24 hours of receipt of request	**For Approvals or Denials**: Within 24 hours after receipt of request. • Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision **<u>Approvals or Denials</u>** ▪ Oral or written notice must be given to member and provider within 24 hours of receipt of request. ▪ When oral notice is given, it must occur within 24 hours of receipt of request and must be followed by written notice to the member within 3 calendar days of the oral notice. ▪ Document date and time oral notice is given. ▪ If written notice only is given, it must be received by member and provider within 24 hours of receipt of request. **<u>Denials</u>**

			▪ When oral notice is given, it must occur within 24 hours of receipt of request and must be followed by written notice to the member within 3 calendar days of the oral notice. ▪ Document date and time of oral notice. ▪ If only written notice is given, it must be received by member and provider within 24 hours of receipt of request. ▪ Use NDMC template for written notification of a denial decision.

Utilization Management Timeliness Standards
(Commercial HMO - California)

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of <u>Denial</u> to Practitioner and Member**
Urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition **<u>not to exceed 72 hours after receipt of the request.</u>**	<u>Practitioner:</u> Within 24 hours of the decision, not to exceed 72 hours of receipt of the request (for approvals and denials). <u>Member:</u> Within 72 hours of receipt of the request (for approval decisions). Document date and time of oral notifications.	Within 72 hours of receipt of the request. **Note:** If oral notification is given within 72 hours of receipt of the request, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
Urgent Pre-Service - Extension Needed • Additional clinical information required	**Additional clinical information required:** Notify member and practitioner within 24 hours of receipt of request & provide 48 hours for submission of requested information.		
	<u>Additional information received or incomplete:</u> If additional information <u>is received</u>, complete or not, decision must be made within 48 hours of receipt of information. **Note:** Decision must be made in a timely fashion appropriate for the member's condition <u>not to exceed 48 hours after receipt of information.</u>	*<u>Additional information received or incomplete</u>* <u>Practitioner:</u> Within 24 hours of the decision, not to exceed 48 hours after receipt of information (for approvals and denials). <u>Member:</u> Within 48 hours after receipt of information (for approval decisions). Document date and time of oral notifications.	*<u>Additional information received or incomplete</u>* Within 48 hours after receipt of information. **Note:** If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of <u>Denial</u> to Practitioner and Member**
	<u>Additional information not received:</u> If no additional information is received within the 48 hours given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 48 hours. **Note:** Decision must be made in a timely fashion appropriate for the member's condition <u>not to exceed 48 hours after the deadline for extension has ended.</u>	*<u>Additional information not received</u>* <u>Practitioner:</u> Within 24 hours of the decision, not to exceed 48 hours after the timeframe given to the practitioner & member to supply the information (for approvals & denials). <u>Member:</u> Within 48 hours after the timeframe given to the practitioner and member to supply the information (for approval decisions). Document date and time of oral notifications.	*<u>Additional information not received</u>* Within 48 hours after the timeframe given to the practitioner & member to supply the information. **Note:** If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of <u>Denial</u> to Practitioner and Member**
Urgent Concurrent - (i.e., inpatient, ongoing/ambulatory services) Request involving both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved and the request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments. **Exceptions:** • If the request is not made at least 24 hours prior to the expiration of prescribed period of time or number of treatments, and request is urgent, default to <u>*Urgent Pre-service*</u> category. • If the request to extend a course of treatment beyond the period of time, or number of treatments previously approved by the Health Plan/PMG/IPA does not involve urgent care, default to <u>*Non – urgent Pre-service*</u> category.	Within 24 hours of receipt of the request.	<u>Practitioner:</u> Within 24 hours of receipt of the request (for approvals and denials). <u>Member:</u> Within 24 hours of receipt of the request (for approval decisions).	Within 24 hours of receipt of the request. **Note:** If oral notification is given within 24 hours of request, written or electronic notification must be given no later than 3 calendar days after the oral notification.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Standing Referrals to Specialists / Specialty Care Centers **-** All information necessary to make a determination is received	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 3 business days of receipt of request. **NOTE:** Once the determination is made, the referral must be made within 4 business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or designee.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.
Non-urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 5 business days of receipt of request.	Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	Within 2 business days of making the decision.
Non-urgent Pre-Service - Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer	**Additional clinical information required:** Notify member and practitioner within 5 business days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made in a timely fashion as appropriate for member's condition not to exceed 5 business days of receipt of information.	Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	Within 2 business days of making the decision.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available in a timely fashion as appropriate for member's condition not to exceed an additional 5 business days.		
	Require consultation by an Expert Reviewer: Upon the expiration of the 5 business days or as soon as you become aware that you will not meet the 5 business day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		
	Require consultation by an Expert Reviewer: Decision must be made in a timely fashion as appropriate for the member's condition within 5 business days of obtaining expert review, not to exceed 15 calendar days from the date of the delay notice to the practitioner and member.	*Require consultation by an Expert Reviewer*: Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	*Require consultation by an Expert Reviewer:* Within 2 business days of making the decision.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Post-Service - All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days of receipt of request.	Practitioner: Within 30 calendar days of receipt of request (for approvals). Member: Within 30 calendar days of receipt of request (for approvals).	Within 30 calendar days of receipt of request.
Post-Service - Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer	**Additional clinical information required:** Notify member and practitioner within 30 calendar days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	Additional information received or incomplete If additional information is received, complete or not, decision must be made within 15 calendar days of receipt of information.	*Additional information received or incomplete* Practitioner: Within 15 calendar days of receipt of information (for approvals). Member: Within 15 calendar days of receipt of information (for approvals).	*Additional information received or incomplete* Within 15 calendar days of receipt of information.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of <u>Denial</u> to Practitioner and Member**
	<u>Additional information not received</u> If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 15 calendar days.	*<u>Additional information not received</u>* <u>Practitioner:</u> Within 15 calendar days after the timeframe given to the practitioner & member to supply the information (for approvals). <u>Member:</u> Within 15 calendar days after the timeframe given to the practitioner and member to supply the information (for approval decisions).	*<u>Additional information not received</u>* Within 15 calendar days after the timeframe given to the practitioner & member to supply the information.
	Require consultation by an Expert Reviewer: Upon the expiration of the 30 calendar days or as soon as you become aware that you will not meet the 30 calendar day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of <u>Denial</u> to Practitioner and Member**
	<u>Require consultation by an Expert Reviewer:</u> Within 15 calendar days from the date of the delay notice.	*<u>Require consultation by an Expert Reviewer:</u>* <u>Practitioner:</u> Within 15 calendar days from the date of the delay notice (for approvals). <u>Member:</u> Within 15 calendar days from the date of the delay notice (for approval decisions).	*<u>Require consultation by an Expert Reviewer:</u>* Within 15 calendar days from the date of the delay notice.
Translation Requests for Non-Standard Vital Documents 1. Urgent (e.g., pre-service pend or denial notifications with immediate medical necessity) 2. Non-Urgent (e.g., post-service pend or denial notifications)	*<u>LAP Services Not Delegated:</u>* All requests are forwarded to the contracted health plan. 1. Request forwarded within one (1) business day of member's request 2. Request forwarded within two (2) business days of member's request		*<u>LAP Services Delegated/Health Plan:</u>* All requested Non-Standard Vital Documents are translated and returned to member within 21 calendar days.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of <u>Denial</u> to Practitioner and Member**
Prescription Drugs CA Health & Safety Code section 1367.241 (CA SB 282; 2015-2016) **Exigent circumstances" exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function **OR** when an insured is undergoing a current course of treatment using a non-formulary drug.*	▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request	<u>Practitioner:</u> ▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request ***NOTE:** CA SB282 does not specify timeframes for member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes.*	<u>Practitioner:</u> ▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request ***NOTE:** CA SB282 does not specify timeframes for member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes.*

IMPERIAL MANAGEMENT
ADMINISTRATIVE SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Adult Preventive Services	
Policy Number(s): 10-015	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP, and Specialist shall follow the procedures set forth in this policy.

PURPOSE

To ensure delivery of all preventive services and medically necessary and treatment services for adult members using the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF)

POLICY

IHHMG shall cover and ensure the provision of all medically necessary diagnostic, treatment, and follow-up services, which are necessary given the finding or risk factors identified in the IHA or during visits for routine, urgent, or emergent health care situations. IHHMG shall ensure that these services are initiated as soon as possible but no later than 60 calendar daysfollowing discovery of a problem requiring follow up.

The USPSTF recommendation requires clinicians in primary care and Referral to Treatmentsettings to screen adults 18 years of age or older for alcohol misuse Screening, Brief Intervention, and Referral to Treatment (SBIRT) and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or provide referrals to mental health and/or alcohol use disorder services. Counseling interventions in the primary care setting can positively affect unhealthy drinking behaviors inadults engaging in risky or hazardous drinking. Based on

this recommendation, (SBIRT) services for alcohol misuse is a Medi-Cal benefit and is targeted at alcohol misuse only.

Providers who meet the requirements (described below) to screen and provide brief intervention for alcohol misuse/abuse, may be reimbursed using HCPCS code H0049 for alcohol screening and code H0050 for brief interventions. These codes are reimbursable in connection with alcohol abuse only and not for drug-related services.

PROCEDURE

Primary care providers (PCPs) may offer SBIRT in the primary care setting as long as they meet the following requirements:

1. SBIRT services may be provided by a licensed health care provider or staff working underthe supervision of a licensed health care provider, including the following:

   1.1. Licensed Physician

   1.2. Physician Assistant

   1.3. Nurse Practitioner

   1.4. Psychologist

2. All licensed health care providers must be trained in order to provide SBIRT services orsupervise individuals who provide them. A minimum of four hours of SBIRT training is required.

3. All non-licensed providers must be trained in SBIRT services in order to provide theseservices and must meet the following requirements:

   3.1. Be under the supervision of a licensed and trained SBIRT services provider.
   3.2. Complete a minimum of 60 documented hours of professional experience such as coursework, internship, practicum, education or professional work within their respective field. This experience should include a minimum of four hours of training thatis directly related to SBIRT services.
   3.3. Complete a minimum of 30 documented hours of face-to-face recipient contact withintheir respective field. (This requirement is in addition to the 60 hours of professional experience described above.) This may include internships, on the job training or professional experience. This contact may include, but does not have to be directly related to, SBIRT services training.

4. Providers must develop policies and procedures that require PCPs and health care teammembers who provide SBIRT services to attest that they have obtained the required training on SBIRT. The PCP is not required to offer the training directly to its providers. DHCS may request verification of the required documentation as part of its audit and oversight responsibilities.

5. DHCS requires the use of the following validated screening tools: The Alcohol Use DisorderIdentification Test (AUDIT) or Alcohol Use Disorder Identification Test−Consumption (AUDIT-C).

Reference(s)
http://www.dhcs.ca.gov/services/medi-cal/Documents/prev_m01o03.pdf

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Blood Lead Screen	
Policy Number(s): 10-016	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP, and Specialist shall follow the procedures set forth in this policy.

PURPOSE

Policy to ensure blood lead screening test to members at ages one (1) and two (2) in accordance with title 17, Chapter 9, Articles 1 and 2.

POLICY

The information contained in this policy letter is in compliance with current Federal and State law and is intended to ensure that all young children in Medical managed care plans receive the blood lead screenings and appropriate follow-up services to which they are legally entitled, in accordance with the standards of care detailed herein.

Oral or written anticipatory guidance to a parent or guardian of the child, including, at a minimum, the information that children can be harmed by exposure to lead, especially from deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. Anticipatory guidance shall be performed at each periodic health assessment, starting at 6 months of age and continuing until 72 months of age.

CHDP Health Assessment Provider Responsibilities for Lead Screening and Guidance:
Children who participate in government assisted health care programs are at increased risk for lead poisoning.[1] The responsibilities of health care providers who care for children in the CHDP program with respect to detection of lead poisoning and anticipatory guidance on lead hazards

and harmful effects are specified in CHDP and Childhood Lead Poisoning Prevention Branch (CLPPB) policy and California Regulations.[2,3]

PROCEDURE

Blood lead testing must be performed at 12 and 24 months of age in all children receiving health care services through CHDP. Blood lead testing must also be performed between 12 and 24 months, if testing was not done at 12 months and between 24 and 72 months in children who were not previously tested or who missed the 24-month test.[2,3] Lead levels may additionally be measured at times other than those specified, if thought indicated by the CHPD health assessment provider or in response to parental concerns.[2,3]

Perform blood lead level (BLL) testing on all children in accordance with the following:
(a) At I2 months and at 24 months **of** age.
(b) When the health care provider performing a periodic health assessment becomes aware that a child 12 to 24 months of age has no documented evidence **of** BLL test results taken at 12 months of age or thereafter.
(c) When the health care provider performing a periodic health assessment becomes aware that a child 24 to 72 months of age has no documented evidence **of** BLL test results taken when the child was 24 months of age or thereafter.
(d) Whenever the health care provider performing a periodic health assessment **of** a child 12 to 72 months of age becomes aware that a change in circumstances has placed the child at increased risk **of** lead poisoning, in the professional judgement of the provider.

The health care provider is not required to perform BLL testing if:
0 A parent or guardian of the child, or other person with legal authority to withhold consent, refuses to consent to the screening.

If blood lead screen test is refused by member, proof for voluntary refusal of the test in the form of a signed statement by the member if an emancipated minor or the parent(s) or guardian of the member shall be documented in the member's medical record.

0 If in the professional judgement of the provider, the risk of screening poses a the risk of screening poses a greater risk to the child's health than the risk of lead poisoning. Providers will document the reasons for not screening in the child's medical record.

Reference(s)
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2002/MMCDPL02001.pdf

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Screening for Chlamydia	
Policy Number(s): 10-017	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP, and Specialist shall follow the procedures set forth in this policy.

PURPOSE

The purpose of this policy is to provide clarification for the Screening for Chlamydia in females less than 21- years of age who have been determined to be sexually active.

POLICY

IHHMG requires that PCP/GYN practitioners screen for Chlamydia, their female patients who are less than 21- years of age and determined to be sexually active.

PROCEDURE

1. When it has been determined that female patient less than 21-years of age is sexually active the PCP/GYN practitioner must initiate the screening for Chlamydia and documentthe findings (results) in the member's medical record

2. The member's voluntary refusal of the screening documented in the member's medicalrecord.

Reference(s)
http://www.dhcs.ca.gov/dataandstats/Documents/HealthDisparities_ChlamydiaScreening.pdf

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATORY SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Vision care - Lenses	
Policy Number(s): 10-018	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP, and Specialist shall follow the procedures set forth in this policy.

PURPOSE

To establish the process by which members are identified and referred for Vision Care for Medi-Cal members.

POLICY

Health Plans are responsible for arranging for the provision of quality vision products, includingoptical lenses and eyewear, for Medi-Cal members in need of new or replacement optical eyewear. Member's glasses are arranged for through a California Prison Industry Authority CALPIA laboratory. Optical eyewear is a covered benefit with a written prescription by a contracting physician or optometrist. Covered services include lenses, contact lenses and frames (in accordance with California Code of Regulations (CCR), Title 22, Section 51317).

The following are not covered benefits:

1. Eyeglasses used primarily for protective, cosmetic, occupational or vocational purposes.

2. Eyeglasses prescribed for other than the correction of refractive errors or binocularityanomalies;

3. Double segment bifocal or no-line multifocal lenses;
4. Multifocal contact lenses

5. Replacement frames, provided the previous frames are not suitable for continued use. If aprevious frame can be made suitable for continued use by adjustment, repair or replacement of a broken front or temple(s) they are considered to be suitable for continueduse. Replacement frames within two years are limited to the same model, whenever feasible.

PROCEDURE

1. Referrals
   1.1. Members may self-refer for annual routine vision services and schedule an appointment with a "contracting optical provider" without prior authorization.

2. Filling a Glasses Prescription

   2.1. The contracting optical provider sends the lens prescription and frame order to the appropriate optical laboratory for production. The optical laboratory manufactures thelenses, inserts them into the frames and returns them to the dispensing provider.

3. Fitting

   3.1. The contracting optical provider ensures that each member receives an appointmentfor a fitting and adjustment of the glasses once the provider receives the glasses.

Reference(s)

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Pregnancy Care Guidelines	
Policy Number(s): 10-019	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP, and Specialist shall follow the procedures set forth in this policy.

PURPOSE

Policies and Procedures to ensure the provision of all Medically Necessary services for pregnant using the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum of quality of prenatal services.

POLICY

IHHMG will implement a comprehensive risk assessment tool for all pregnant female members that is comparable to the ACOG standard and Comprehensive Perinatal Services Program (CPSP) standards per Title 22, CCR, Section 51348.

The results of this assessment shall be maintained as part of the obstetrical records and shall include medical/obstetrical, nutritional, psychosocial and health education needs risk assessment components.

PROCEDURE

1. Referral to Specialists: IHHMG shall ensure that pregnant women at high risk of a poor pregnancy outcome are referred to appropriate specialists including perinatologists andhave access to genetic screening with appropriate referrals.
2. The IPA ensures that pregnant members are offered pregnancy services in

theComprehensive Perinatal Services Program (CPSP)

3. In the event the member refuses the CPSP program. The refusal shall be documented inthe member's medical record.

Reference(s)
Policy: Comprehensive Perinatal Services Program CPSP #05-01-16-05-004

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATIVE SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Alcohol and Drug Abuse	
Policy Number(s): 10-020	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:**  **03/25/21**	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: **Date:** Josie Wong **03/25/21**
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP, and Specialist shall follow the procedures set forth in this policy.

PURPOSE

POLICY

IHHMG Medi-Cal member's treatment for Alcohol and Drug abuse is available under the Drug Medi-Cal Program as defined in Title 22, CCR, Section 51341.1.

IHHMG shall continue to ensure the provision of primary care and other services unrelated to the alcohol and substance abuse treatment and coordinates services between the PCP and the treatment programs.

PROCEDURE

The IHHMG utilization management staff shall upon receipt of a request for authorization for Alcohol and/or Drug Abuse treatment shall notify the requesting practitioner that the services are provided by the Medi-cal MHP and that the member's medical services are still covered and provided through IHHMG.

The PCP is informed that the member's medical care is continued through IHHMG and care coordination process continues with the member's primary care provider. IHHMG shall continue to cover and ensure the provision of primary care and other services unrelated to the

alcohol and substance abuse treatment and coordinate services between the primary careproviders and the treatment programs

The IHHMG utilization management department shall issue a notification informing the member that the requested Alcohol and/or Drug Abuse treatment is not covered by their healthplan and is covered through the medi-cal MHP. In addition, the member is notified that their medical services are still covered and provided by IHHMG.

Reference(s)

Attachments:
See Specialty Mental Health policy - #05-01-16-05-020

IMPERIAL MANAGEMENT
ADMINISTRATIVE SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Services for children with Special Health Care Needs (CSHCN)	
Policy Number(s): 10-021	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP, and Specialist shall follow the procedures set forth in this policy.

DEFINITION

Those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally"

PURPOSE

POLICY

It is the policy of IHHMG that CSHCN cases and potential cases identified shall be managed and referred to the appropriate agency for the services available per DHCS Regulations.

Identification of CSHCN:

1. Chronic condition codes

1.1.4-severitylevels

1.1.1. Mild – Included, but not limited to:

1.1.1.1. Attention deficit/hyperactivity disorder

1.1.1.2. Chronic joint/musculoskeletal diagnosis

1.1.1.3. Chronic eye diagnosis

1.1.1.4. Depression (non-major)

1.1.1.5. Chronic Mental Health diagnosis

1.1.2. Moderate – Included, but not limited to:

1.1.2.1. Asthma

1.1.2.2. Conduct, impulse control, other disruptive behavior disorders

1.1.2.3. Depressive and other psychoses

1.1.2.4. Diabetes

1.1.2.5. Curvature or anomaly of the spine

1.1.2.6. Chronic mental health diagnoses

1.1.2.7. Chronic alcohol abuse

1.1.2.8. All other conditions in this status

1.1.3. Major and Extreme – Included, but not limited to:

1.1.3.1. Malignancies & catastrophic conditions

1.1.3.2. Spinal Bifida

1.1.3.3. Acute lymphoid Leukemia

1.1.3.4. Cystic Fibrosis

1.1.3.5. Other malignancies

1.1.3.6. All other conditions in this status

PROCEDURE

CSHCN cases shall be identified through utilization management data, claims data, as well asProvider Encounter data. Upon identification the Utilization Management Nurse shall refer thecase to the appropriate entity, including the member's health plan.

The Utilization Management nurse shall notify the member's PCP of the pending referral.

The Utilization Management nurse shall obtain clinical records from the member's PCP and Specialists for submission to the appropriate agency for additional services/coverage, such as CCS, California Department of Mental Health, etc.

Logs of referrals shall be maintained by the UM department and submitted to the health plansas required.

Reference(s)
http://www.dhcs.ca.gov/services/ccs/Documents/IDCronicConditions.pdf

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATIVE SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Services for Persons with California Children Services (CCS)	
Policy Number(s): 10-022	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:**  **03/25/21**	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: **Date:** Josie Wong **03/25/21**
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group shall follow the procedures set forth in this policy.

PURPOSE

To identify and monitor all Medi-Cal and Commercial patients, ages birth to twenty-one, with potential CCS eligible conditions/diagnosis. To identify such cases as early as possible and tocase manage those patients efficiently and effectively.

POLICY

1. The California Children Service (CCS) Program provides medically necessary servicesand case management for Medi-Cal beneficiaries with CCS eligible conditions or diagnoses who meet program eligibility requirements in accordance with California Code of Regulations (CCR) Title 22, Section 41510 and 51013, and California Health and Safety Code Section 1238.00.

2. Potential CCS patients will be identified at as early as is feasible. As part of their casemanagement, all financial and medical elements involved in the care of these patients will be tracked.

3. Scope: PCPs, Specialists, UM Case Managers, Health Case Managers, CCS Panel Facilities.

PROCEDURE

1. IPA, Health Plan, and Public Health Coordination

The UM staff interfaces with the Health Plan Coordinators and Hospital Case Managers who collaborate with the County CCS liaison to confirm CCS eligibility and to obtain the CCS authorization number.

NOTE: The IHHMG will not deny services pending CCS approval or determination.

Member Identification

A. The PCP/ Attending Provider identify members with CCS eligible conditions based on CCS criteria (listed in the Provider Manual) andarrange for their timely referral to the county CCS program.
B. HMO members who are potentially CCS eligible may be identified by anyof the following resources:
   a. During initial health assessments
   b. PCPs and specialists
   c. Inpatient admissions (concurrent review)
   d. Care Management Department
   e. Emergency room/urgent care usage
   f. Health Education Department
   g. Referral Authorization data
   h. Claims data
   i. PM160 form (standard CHDP encounter form)
   j. Encounter data
   k. School based programs
   l. Member Relations Department

Inpatient Review:

If during the course of inpatient review, t h e UM Nurse reviewer or the hospital states to them that the diagnosis could be a CCS condition- the UM Staff shall:

A. Establish if the hospital has a CCS worker there that will be making the CCSreport
B. If not, the UM Nurse is responsible to make the report;
C. After the report has been made to CCS, the UM Nurse shall notify the health plan Case Management Department.

Referral Process

A. Referrals to the CCS program are accepted from any source (PCP, other medicalproviders, family members or any of the above sources are examples).
B. PCPs and specialty providers identify and appropriately refer potentially eligiblechildren to the local CCS office. They inform the family and encourage their participation in the application process and program.
C. UM Nurse or designee is responsible for tracking all potential CCS patients.

When referred through the organization, the UM Nurse shall ensure that there is a completereferral packet submitted to CCS. This includes:

1. CCS referral form or letter with required demographic information
2. Diagnosis or explanation of medical condition for which the child is beingreferred.
3. Current, relevant medical records
4. Delineation of service(s) being requested
5. Treating Physician, if known (name of the CCS paneled provider)
6. Referral source's name, address and telephone number
7. Name of Health Plan
8. Application for services (if available, completed by the parent or legal guardian)

D. If the member does not meet CCS program eligibility criteria, the IPA/Health Planassists the PCP or specialist in evaluating the availability of other programs and services.

E. The PCP or specialist is responsible for ensuring continuity of care during the timethe local CCS Program is determining eligibility status.

F. If a member is identified with a CCS eligible condition but has not been referred toCCS and is not currently in the program, the IPA and Health Plan Care Managersfacilitate the CCS referral in coordination with the PCP and office staff within 24 hours of identification.

G. If the member is currently in the CCS Program, but the PCP is not aware that the member is receiving services through the CCS program, the UM department and /orHealth Plan Case Manager notifies the PCP or specialist and assists in the coordination of care with the CCS Case Manager.

H. For those members who are directly referred to CCS by other sources, the IPA requests the CCS liaison to notify the IPA Care Manager within 48 hours to promotethe coordination of services.

Acceptance into the CCS Program and Authorizations

A. When members are accepted into the CCS Program, CCS initiates contact with thechild's family/legal guardian to request completion of the program application.

B. Once CCS eligibility is determined by the county CCS program, CCS assumes case management, including prior authorization of all services related to the CCS condition.

C. All CCS services require prior authorization, with the exception of emergency services and services rendered after CCS office hours. The CCS program must be notified of thatan emergency service was rendered by the next business day for the date of coverage to include the day the service was rendered.

D. All CCS services must be rendered by CCS paneled providers, CCS approvedfacilities and/or special health care centers.

E. A request for medical services is reviewed by the CCS program and the program mails written notification of authorization or denial to the CCS paneled provider, thechild's family/legal guardian and Health Plan.

    1. Health Plan's Care Manager communicates the authorization or denial to the member's PCP and forwards a copy of the written CCS responsethe IPA UM department.
    2. For hospitalized members, Facility and Health Plan Care Managersfacilitate the coordination of services between the

hospital, IPA UMNurse, PCP, Specialist, CCS, ancillary services and the member's family.

Case Review after CCS Denial

A. When CCS determines that a referred member is ineligible for CCS services, T he CCS program will send a *Notice of Action* to the member's legal guardian and notifythe HMO of that decision.

1. If the PCP, IPA or Medi-Cal Medical Director determines that the eligibility decision was appropriate, the PCP or specialist, IPA UM Nurse and the Health Plan Care Manager collaborate to develop acare plan.
2. If the PCP, IPA or Health Plan Medi-Cal Medical Director disagree withCCS regarding their decision, he/she attempts to resolve the issue at the local level with the CCS Medical Consultant.
    a. In the case where no resolution is obtained between the IPA Medical Director and the CCS Medical consultant, the issue is referred to Health Plans Medical Director for reviewand action. If resolution still does not occur, the case is referred to Health Plan's Public Health Coordinator for the initiation of the problem resolution process.

Case Management

A. UM Nurse or designee confers with the local CCS Case Manager to facilitatecoordination of services and continuity of care.
B. Assists the PCP or Specialist with coordination of care for non-CCS• related conditions,CCS services, and additional services as appropriate.
C. UM Nurse or designee ensures that appropriate referrals to CCS are generated and promotes continuity of care. The UM Nurse or designee shall maintain a list of networkphysician/providers that includes CCS paneled PCPs & Specialists.
D. UM Nurse or designee may utilize the following state maintained website which listsapproved facilities and provider for out-network CCS referrals as appropriate:
    1. http://www.dhcs.ca.gov/services/ccs/Pages/CCSProviders.aspx#paneled

Out-of-Area CCS Case Management Coordination

A. Health Plan's Case Managers are available to coordinate care for CCS• related conditions when CCS Case Managers authorize services out of the member's localservice area.
B. Health Plan's Case Managers coordinate with CCS Case Managers and the member'sPCP when CCS-eligible members access emergency services out of area.

PCP Responsibilities

The PCPs are responsible to:

A. Identify children with CCS eligible conditions as early as possible.
B. Provide a complete baseline health assessment and diagnostic evaluation sufficient toascertain the evidence or suspicion of a CCS-eligible condition.
C. Refer children with CCS-eligible conditions to the county CCS program in a timelymanner.
D. Identify children with CCS eligible conditions as early as possible.
E. Provide a complete baseline health assessment and diagnostic evaluation sufficient toascertain the evidence or suspicion of a CCS-eligible condition.
F. Refer children with CCS-eligible conditions to the county CCS program in a timelymanner.
G. Develop and implement procedures for tracking the identified children and the servicesprovided to them to ensure coordination and continuity of care.
H. Ensure appropriate documentation in the member's medical records relating to thediagnosis and care of the CCS-eligible condition.
I. Respond to requests from CCS Case Managers to coordinate and provide necessarymedical records relating to the CCS diagnosis or condition.
J. Communicate and coordinate services with the CCS panel provider.

Tracking and Monitoring CCS Cases

A. The UM department will ensure that submission of monthly CCS reports to Health Plans.

Reference(s)

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Services for persons with Developmental Disabilities – Regional Centers	
Policy Number(s): 10-023	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP, and Specialist shall follow the procedures set forth in this policy.

PURPOSE

To describe the process by which members are identified and referred to Regional Centers forthe developmentally disabled for evaluation and access to the non-medical services provided through the Regional Centers such as but not limited to, respite, out of home placements, and supportive living.

POLICY

IHHMG primary care physicians (PCPs) must provide eligible Medi-Cal members with all medically necessary and appropriate developmental screenings, primary preventive care, anddiagnostic and treatment services. For members at risk of parenting a child with a developmental disability, the health plan provides genetic counseling and other prenatal genetic services when medically indicated.

The health plan provides for primary care and medical case management for developmentally disabled members and assures coordination with the appropriate local Regional Center for health care services rendered to the eligible member. Preventive care services are provided according to American Academy of Pediatrics (AAP) guidelines for children and the United States Preventive Services Task Force (USPSTF) guidelines for adults.

PROCEDURE

1. Public Health Coordination of Services

- Health Plan's Public Health Programs Administrators collaborate with
- Regional Centers to:

  - Negotiate the Public Health Agreement.
  - Develop coordination policies and procedures.
  - Provide training to health plan staff and contracting physicians.
  - Identify opportunities to share resources that maximize positive health outcomes. Communicate routinely to share data regarding health careencounters and program enrollment figures.
  - Monitor appropriate coordination of care between the health plan andRegional Centers.
  - Work to resolve problems on a local level.
  - Provide reports to the health plan's QI Committee as requested.

1.2 Public Health Programs Administrators also provide information to the LocalInteragency Coordination Area on care management outcomes.

1.3 Health Plan Medical Directors meet as necessary with Regional Centers toexamine challenges to opportunities for improving collaboration.

1.4 Health Plan staff update IHHMG regarding agreements and discussion

Member Identification

Members who are potentially eligible for Regional Center services may be identified bythe following sources:

Community-based organizations

Initial health assessments

Primary care physicians and specialists

Inpatient admissions (concurrent review)

Health Services Department, Government

Programs Medi-Cal Member Services Department

Emergency Room/Urgent Care usage

Public Health Programs Administrator

Provider Inquiry Department
Authorization data

Claims data
Encounter
data

Community Relations
Department

Member

Schools

2. Eligibility Determination

2.1 Prior to receiving services from a Regional Center, a person must be determined tobe eligible under one of the following categories:

Developmental Disability

"Developmental disability" means a disability that originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutesa substantial handicap. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, developmental disability shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shallalso include handicapping conditions found to be closely related to mental retardationor require treatment similar to that required for

mentally retarded individuals, but shall not include other handicapping conditions thatare solely physical in nature (Welfare & Institution Code, Section 4512a).

Persons at Risk

Preventive services may be provided to any potential parent determined to be at highrisk of parenting a child with a developmental disability, and at the request of the parent or guardian, to any infant at high risk of becoming developmentally disabled (Welfare & Institution Code, Section 4644).

There is no financial eligibility requirement for Regional Center services;

however, parents are required to pay based on a sliding fee scale for out• of-home placement for children under 18 years of age. Families are responsible for primary medical and health care for their children as well as those services normally providedto a child without disabilities.

All persons receiving services must be residents of the State of California and shall apply to the Regional Center in whose catchment area they reside.

3. Intake and Assessment

Regional Centers must accept for evaluation and eligibility assessment personsbelieved to have a developmental disability (Welfare & Institution Code, Section4642).

The initial intake must be performed within 15 working days following a request forassistance. Assessment must be performed within 120 working days, or within 60days, if delay in initiating services would seriously impact mental or physical development.

Determination of Regional Center eligibility is the responsibility of the Regional Center interdisciplinary team. As mandated by Title 17, the interdisciplinary team must include the service coordinator, a physician, and a psychologist. The assessment process includes collection and review of available medical history, diagnostic data, provision or procurement of necessary tests and evaluations, andsummarization of developmental/intellectual and adaptive levels of functioning as

well as service needs.

IHHMG Primary Care Physicians (PCPs) assist Regional Centers in obtaining medical records, diagnostic tests and specialty consultations as needed to obtain a complete diagnosis.

In situations where a child is eligible for both California Children Services (CCS) andRegional Center services the first referral should be to CCS if diagnosis or treatmentfor CCS eligible conditions is the major concern. The PCP may wish to notify CCS and the appropriate Regional Center simultaneously if both medical and early intervention services (e.g.: supportive living) are necessary.

If case management services are not needed, the Health Services staff document findings and actions in the health plan's Medical Management database.

The Health Plan' Health Services Department contacts the parent/guardian forapproval to discuss the member's case with the Regional Center.

If parent/guardian approves involvement of Regional Center, the health plan's Health Services staff coordinate individual Family Service Plan with the RegionalCenter's Case Manager.

If the member was not previously referred or accepted into the Regional Center,the Health Services staff contacts the PCP or Specialist Provider and family regarding assistance with referral process.

If assistance is requested, the Health Services staff coordinate with the family andPCP to complete the referral process according to the health plan's desk procedures.

- If the member is accepted into the Regional Center, the health plan's HealthServices staff assess the case to determine if further care management is needed.
    - If care management services are not needed, the Health Services staffdocuments findings and actions in the health plan's Medical Management database.
    - If care management services are required or requested, the Health Services staff follow the health plan's desk procedures and contacts theparent/guardian for approval to discuss the member's case with the Regional Center.
- If the member is not accepted into the Regional Center, the health plan's
    - Health Services staff confer with the PCP and/or Specialist Providerand family and coordinates referral to the Public Health Programs Administrator for problem resolution.
    - The health plan's Health Services staff informs the member/family of the fair hearing process and keeps the family informed about Health Plan's problem resolution process.
    - Disagreements concerning administrative and coverage regulations that involve EPSDT Supplemental Services determination will be forwarded tothe Department of Health Care Services (DHCS) designated authority fordetermination.

Reference(s)

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Services provided under the Home and Community - Based Services (HCBS) Waiver Programs	
Policy Number(s): 10-024	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP, and Specialist shall follow the procedures set forth in this policy.

PURPOSE

To ensure the needs of physically and possibly mentally disabled Medi-Cal recipientsare identified and referred to the In- Home Operations (IHO) Administered HCBS Waiver Program

POLICY

IHO, within the California Department of Health Services, Medi-Cal Operations Division, has statewide administrative responsibility for reviewing and authorizing home and community-services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefits or through three home and community-based service (HCBS) waivers. These services are authorized for Medi-Cal members whomeet medical necessity criteria for the requested services.

IHO authorizes Pediatric Day Health Care (PDHC) and medically necessary services in the home, including long-term private duty nursing services, also known as shift nursing.

HCBS Waiver services are an array of services designed to support individuals in either a home or community-based setting as an alternative to care in a licensed health care facility. The goal is identifying and refer chronically ill Medi-Cal members, including members with developmental disabilities, catastrophic illnesses,technologically dependent and/or at risk of life threatening conditions to the IHO intake unit for evaluation. If a health plan member meets the criteria for IHO Administered HCBS Waiver Program and is accepted into the waiver program, themember is then dis-enrolled from the health plan and enrolled into the Medi-Cal Fee-For-Service (FFS) Program.

The IHO Administered HCBS Waivers are creative alternatives to be implementedin the home or community for Medi-Cal members to avoid hospitalization or nursing facility placement. Services provided under waivers are all carved-out referral services and require prior authorization from the IHO Intake Unit.

PROCEDURE

1. Health Plan's Public Health Program Administrators:

    1.1. Develop coordination policies and procedures.

    1.2. Provide in-service training to health plan internal staff and participating providers.

    1.3. Identify opportunities to share resources and maximize positive health outcomes.

    1.4. Communicate with HCBS as needed to facilitate exchange of information anddata.

    1.5. Provide ad hoc reports to the health plan's Quality Improvement Committeeas requested.

    1.6. Coordinate meetings between health plans, health plan's subcontractors,HCBS Case Managers as needed.

    1.7. Work to resolve problems on a local level.

    1.8. Conduct an inventory and prepare a list of all agencies that render supportivecare services within the geographic region.

    1.9. Distribute the listing/directory of supportive care agencies and eligibility criteriato internal departments, participating providers and other sources listed belowin member identification.

    1.10. The Health Plan Program Administrators shall communicate decisionsand discussions with IHHMG.

1.10.1. Member Identification (potentially eligible members may beidentified through any of the following sources):

1.10.1.1. Community-based organizations

1.10.1.2. Initial health assessments

1.10.1.3. Primary care physicians and specialists

1.10.1.4. Inpatient admissions (concurrent review)

1.10.1.5. Health Services Department, Government Programs Medi-CalMember Services Department

1.10.1.6. Emergency Room/Urgent Care usage

1.10.1.7. Health Net Public Health Programs Administrator

1.10.1.8. Health Education

1.10.1.9. Department

Provider1.10.1.10.Inquiry

Department

1.10.1.11. Authorization data

1.10.1.12. Claims data

1.10.1.13.Encounter

data

1.10.1.14.Community Relations Department

2. Referral and Coordination Process

2.1. Health Plan's Services Department or subcontracting providers' monitorsand reviews all inpatient stays to determine appropriate utilization and to identify members who may potentially benefit from a HCBS waiver program.

2.2. Health Plan's Services Department or subcontracting providers reviews the potentially eligible member's medical needs and prognosis for ongoing care with the PCP and Inpatient Facility Discharge Planner/Case Manager.

2.3. The member's PCP informs the member, family/guardian or authorized representatives about the availability of in-home carealternatives.

2.4. Upon consent of the member, family/guardian or authorized representative, the appropriate Medi-Cal provider of service submits a request for services tothe IHO Intake Unit.

2.5. The PCP prescribes services necessary to meet the in-home care needs of the member.

2.6. Provision of waiver services is dependent upon concurrence of the member, family/guardian or authorized representative, PCP, and a licensed and Medi-Cal certified home health agency. The Department ofHealth Services (DHS) requires each party to sign a letter of agreement to ensure that all waiver participants understand their roles and responsibilities, as well as the benefits and limitations of the waiver.

2.7. The home health agency or appropriate Medi-Cal provider of service is responsible to prepare all necessary requests for services including a Treatment Authorization Request (TAR) and appropriate medical documentation to support the requested services. Documentation for request for services may be faxed, mailed, phoned or hand delivered to theIHO Intake Unit.

In-Home Operations Section- Intake Unit
Department of Health Services-Medi-Cal
OperationsDivision 700 North Tenth Street, Suite 102

P.O. Box 942732
Sacramento, CA 94234-7320(916) 324-1020

2.8. The home health agency provides a copy of all documentation for the healthplan's Care Manager for tracking and follow-up coordination.

2.8.1. The IHO Unit staff assesses the member's medical condition to determine w h e t h e r the individual would be appropriate for waiver services and which waiver program (IHMC, SNF or Model-NF) would bethe most appropriate.

2.9. The IHO unit reviews the request to ensure that necessary, appropriate and q u a l i t y medical and nursing services are authorized and rendered in

the home setting. The IHO staff prepares the proposal document and allows for
review of all issues related to the recipient level of care, evaluation of durablemedical equipment, medication, nursing hours, cost-effectiveness and verification by IHO staff that the home environment is appropriate to meet thehealth and safety needs of the recipient. Final approvals of individual waiver requests are subject to review by a Medi-Call physician as well as the DHS IHO staff.

2.9.1. To meet the home care needs of the eligible member the IHO unit mayapprove and authorize the following services:

3. Home Health Case Management: Weekly Registered Nurse supervisor services;

3.1. Skilled Nursing Care: Hourly nursing services provided by Registered Nurses (RN) and/or Licensed Vocational Nurses (LVN);

3.2. Home Health Aide Services: Services provided by a certified individual andsupervised by an RN or LVN;

3.3. Modification to the Home: Consisting of minor physical adaptations that enable the eligible member to receive care at home;

3.4. Utility Costs: Reimbursement for costs incurred due to the continuousoperation of life-sustaining equipment.

3.5. As prescribed by the member's PCP, the IHO unit may approve services up to 24 hours per day. However, the approval of HMC services ideally involves the active participation of the family and/or primary caregiver in the home c a r e program, as well as sufficient direct patient care to ensure the continued health and safety of the member. The family member(s) and/or a primary caregiver is required to be proficient in the tasks necessary to care forthe beneficiary at home to ensure care is not interrupted by an unforeseen event (for example, the inability of a home health agency to provide nursing services due to a natural disaster or staff illness or shortages).

This proficiency requirement may be satisfied by training as necessary to safely carry out the plan of treatment and by providing four or more hours ofcare to the member each week.

4. Entry into IHO-Administered Home and Community Based Waiver Program

4.1. Upon acceptance by the IHO unit and acceptance into a local home health agency, the Health Plan's Health Services Department contacts the Medi-CalMember Services Department to initiate the disenrollment process and

facilitate an orderly transfer of medical service responsibility from the Health Plan to the Medi-Cal FFS Program.

4.2. The health plan's services department contacts the member's PCP to notifythem of the member's acceptance into the waiver program.

4.3. The health plan's PCP and Health Services staff coordinate with the IHO Administered HCBS Waiver Program and the Medi-Cal FFS provider regarding the transfer of the member's care.

4.4. In the event the health plan is in disagreement with the IHO unit decision and/or recommendation concerning the provision of waiver services, the health plan's Public Health Programs Administrator initiates the Problem Resolution Procedure

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ATTACHMENT 1

HOME AND COMMUNITY BASED WAIVER SERVICES AVAILABLE

Following is a description of the services available to Medi-Cal members who are selected for participation in the In-Home Operations Administered and Community Based Services Waiver Program.

Adult Foster Care: Personal care and services, attendant care and companion services provided in a licensed (where applicable) private home by a principle care provider (not a parent) who lives in the home.

Assisted Living: Personal care services, homemaker, chore, attendant care, companion services, medication oversight, therapeutic social and recreational programming, providedin a licensed community care facility, while living in the facility.

Chore Services: This service includes heavy household chores such as washing floors, windows and walls, tracking down loose rugs and tiles, moving heavy items of furniture in order to provide a safe environment.

Communication Aides: Human services necessary to facilitate and assist members with hearing, speech, or vision impairment to be able to effectively communicate with service providers, family, friend, co-workers, and the general public.

Crisis Intervention Facility Services: Immediate, temporary (less than 30 days) placement in a specialized residential setting, and immediate, intensive, face-to-face therapeutic treatment service for members exhibiting acute personal, social, and/or behavioral problems which present an immediate and serious threat to the health andsafety of the individual or others.

Day Habitation: Assistance with the acquisition, retention, or improvement in self-help, socialization and adaptive skills.

Environmental Accessibility Adaptions: Physical adaptions to the home including rampsand grab-bars, widening doorways, modifying bathrooms or installing specialized electric and plumbing systems necessary for medical equipment and supplies.

Home and Health Aide Services: Services are provided to a member by a licensedregistered nurse, a licensed practical or vocational nurse under the supervision of a registered nurse or through a home health agency.

Homemaker: General household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herselfor others in the home.

Mobile Crisis Intervention: Immediate therapeutic intervention on a 24-hour emergency basis to an individual exhibiting acute personal, social, and/or behavioral problems.

Nutritional Consultation: Services include the provision of consultation and assistance in planning to meet the nutritional and special dietary needs of the members.

Personal Care Services: Services include assistance with eating, bathing, dressing, personal hygiene, activities of daily living, laundry, and shopping.

Personal Emergency Response Systems (PERS): A 24-hour emergency assistanceservice which enables the member to secure immediate assistance in the event of an emotional, physical, or environmental emergency.

Respiratory Therapy Services: Services that are targeted towards members who require these services but who do not meet the criteria for regular Med-Cal or are provided in addition to regular Medi-Cal services if necessary.

Respite Care: Services given to individuals unable to care for themselves, provided on ashort term basis because of the absence or need for relief of those persons normally providing the care.

Skilled Nursing: Services provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse.

Specialized Medical Equipment and Supplies: Includes devices, controls, or appliances, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which theylive.

Transportation: Service offered to enable consumers access to waiver and other community services and resources, and include transportation aides and such otherassistance as is necessary to assure safe transport.

Vehicle Adaptations: Devices, controls, or services which enable members to increase their independence or physical safety, and which allow the member to live in their home.

The following services are offered in addition to those available through regular Medi-calin order to provide the amount of care necessary to prevent institutionalization.

Physical Therapy Services

Occupation Therapy Services

Psychology Services

Reference(s)

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATIVE SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Local Education Agency(LEA) Services	
Policy Number(s): 10-027	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** **03/25/21**	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** **03/25/21**
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP's, and Specialist's, and Providers shall follow the procedures set forth in this policy.

PURPOSE

The purpose of this policy is to ensure that IHHMG Members are referred to the LEAs including the Public Schools and District offices for services included, but not limited, such as psychological assessments, health and nutritional education programs

POLICY

IHHMG shall ensure that its Primary Care Physicians (PCPs) and Specialists refer

I H H M G m e m b e r s t o t h e Local Educational Agency (includes public schools and district offices) for health assessments, educational, developmental, and psychosocial assessments, health and nutrition education programs as specified in Title 22, CCR, section51360 provided to students who qualify based on Title 22, CCR.

PROCEDURE

1. The IHHMG referring practitioner shall confirm eligibility with IHHMG; the practitioner mayrefer members to the LEA who are actively eligible through their Medi-Cal Managed CarePlan.

2. Services provided by Local Educational Agencies (LEAs) are excluded from coverage under Medi-Cal and some other health plan lines of business.

3. LEAs through the public schools and district offices provide mandated health assessments, educational, developmental, and psychosocial assessments. Educational programs include health education and nutrition education programs.

4. Children and young adults under the age of 22 may avail themselves of these services. The PCP will assist parents in obtaining necessary testing and evaluation through the school. Parents and guardians may request help with behavioral and learning issues from the PCP.

5. PCPs, specialty care physicians, and case managers can assist members or their parentsor guardians in accessing these necessary services within a timely manner.

6. The PCP may be asked to assist the school district in providing medical evaluations to classify services under Section 504, IDEA, or ADA guidelines. Medical records and confidential personal health information will be released under relevant and current statutes.

    6.1. Public Law 94-142, Part B of the Individuals with Disabilities Act has guaranteed special education services for children with a variety of disabilities. Part B of IDEA requires schools to identify and promptly evaluate children at no charge to the parents,to determine the child's needs and develop an Individualized Educational Plan (IEP).

    6.2. Section 504 of the Rehabilitation Act of 1973 requires that school systems make a "freeand appropriate public education" available to eligible and qualified children with disabilities.

Reference(s)

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Child Health and Disability Prevention (CHDP) Activity	
Policy Number(s): 10-028	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:** 09/01/19
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP's, and Specialist's, and Providers shall follow the procedures set forth in this policy.

PURPOSE

To establish a mechanism to assure the delivery of CHDP services to Medi-Cal Managed Care members under age 21, and to effectively track, monitor, and report the utilization of these services. To ensure that the periodic screening assessment and preventive health care is completed as required by the AAP and CHDP guidelines.

POLICY

It is the policy of IHHMG that eligible under 21 years of age are to have access toand receive Child Health and Disability Program (CHDP) services in accordance with State and federal requirements for providing preventive services to children.

PROCEDURE

A. The provision of CHDP services is accomplished through IHHMG providers and/or local health department and school-based programs in accordance with L.A. Care'sMemoranda of understanding. Physicians that see LA Care members under the ageof 16 must be CHDP certified.

B. Services are provided in accordance with the most current CHDP

standards(https://www.dhcs.ca.gov/services/chdp/Pages/Pub156.aspx).

C. The PCP will ensure that performance of the CHDP age appropriate assessment isconducted at the time of the Initial Health Assessment (IHA).

   a. PCP must make arrangements for any needed follow-up services that reflectthe findings or risk factors discovered during the IHA and health education behavioral assessment.

   b. The initial assessment must include, or arrange for provision of, all immunizations necessary to ensure that the child is up-to-date for age, and anage appropriate Individual Health Evaluation Behavioral Assessment (IHEBA).

D. Refusal of CHDP services are documented in member's medical record.

E. Providers will follow AAP periodicity tables, which requires more frequent visits thandoes the periodicity schedule of the CHDP schedule.

F. The referral process will include, as necessary: California Children's Services (CCS),Regional Center, Early Start/Early Intervention/DDS, County Mental Health, and Women, Infants and Children Program (WIC), EPSDT.

G. IHHMG will ensure that monitoring and improving utilization of CHDP services is anongoing process, including: provider education (i.e., office onsite follow up, monitoring feedback – faxes/letters); online training through the IHHMG website (http://imperialhealthholdings.com/provider-resources/); and IHHMG reports (i.e., encounter data).

H. Identified Problems:

IHHMG Medi-Cal enrollees under 21 years of age are to receive an initial health assessment within 120 days of enrollment. An IHA consists of a comprehensive health history and physical examination and includes an age appropriate health education behavioral assessment.

The assessment must include but not limited to, the following: CHDP standards, including: screening and immunization schedules for specific age groups. The CHDP health screening also includes a comprehensive health historywhich collects information on the following areas:

- Social/Cultural
- Environmental
- Family Health
- Prenatal, Birth, Neonatal
- Development
- Physical Growth
- Nutrition
- Allergies
- Illnesses
- Accident
- Hospitalizations
- Immunizations
- Communicable Diseases

The physical examination must be given while the member is unclothed. Attention therefore should be given to the age of the patient and his/her need for privacy. The physical examination must include, but is not limited to:

- Skin
- Hair
- Head
- Heart
- Spine
- Abdomen
- Eyes (Vision Testing)*
- Genitals (Pelvic Exam)*
- Ears (Audiometry)*
- Extremities
- Neck
- Lungs
- Height and Weight
- Head Circumference
- Nose, Throat, Mouth, Gums, Dental Screen Blood Pressure,Pulse
- Palpation of femoral, brachialand radial chest

**according to periodicity schedules*

Tests are to include the following:

- Lead screening
- Hemoglobin or hematocrit
- Tuberculin tests
- Cholesterol screening
- STD screening

I. Follow-Up On Conditions Identified During CHDP Exams

The physician network will arrange for any medically necessary service identified through a health assessment (or episodic exam). Treatment for these conditions is to be initiated within 60 days. Medical records must contain a justification if disenrollment occurs in the interim. Primary Care Physicians will coordinate care with the CHDP office 7.8.3: Regional Centers.

Regional centers provide overall case coordination for eligible members and theirfamilies to assure access to health, developmental, social, educational and vocational services. Services are provided on a case by case basis, taking into consideration the availability of generic services appropriate to the consumer's needs.

IHHMG members who appear to qualify for regional center services will be appropriately identified and referred in accordance with the specifications of the Regional Center Program. This applies to the following:

a) Persons three (3) years of age and older with or suspected to have a developmental disability
b) Persons from birth to 36 months who are at risk of developing a

developmental disability

c) Persons at risk of parenting a child with a developmental disability (genetic)

d) Individuals with a medical diagnosis which includes:

- Mental retardation
- Epilepsy
- Autism
- Cerebral Palsy

Other handicapping conditions closely related to mental retardation and requiring treatment similar to that required by persons with mental retardation.

Other applicable factors are that the condition:

- Must manifest prior to age 18
- Is likely to continue indefinitely
- Constitutes a substantial handicap

Factors that do not apply:

- Solely psychiatric disorders
- Solely learning disabilities
- Solely physical in nature (i.e. hearing impairment, vision impairment,orthopedic, etc.)

J. Completing Form PM 160:

05-28 PM 160 INSTRUCTIONS.doc

Reference(s)

AAP Periodicity Table.pdf

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATIVE SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Dental Services	
Policy Number(s): 10-029	**Orig. Date:** 05/01/19
Effective Date: 05/01/19	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ **IHP** ☒ **IHHMG** ☒ **IICT**	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP's, and Specialist's, and Providers shall follow the procedures set forth in this policy.

PURPOSE

It is the purpose of IHHMG its PCPs shall refer members under 21 years of age for dental care as needed at least annually, beginning at age 3- years or earlier if condition warrants.

POLICY

Dental Services are considered a **Carve Out Benefit** and are not covered through thephysician network. The Medi-Cal member may go to any FFS Dentil-Cal provider.

Assistance shall be provided to the member in locating a provider, by calling Denti-Cal at (800) 322- 6384.

PROCEDURE

Written policy and procedures for referral of member for dental services as part of the initial health assessment under 21 years of age which includes dental screening/oral health assessment, with annual dental referrals made commencing at age 3 or earlier if conditions warrant.

Reference(s)

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATIVE SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Direct Observed Therapy (DOT) for Treatment of tuberculosis(TB)	
Policy Number(s): 10-030	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP's, and Specialist's, and Providers shall follow the procedures set forth in this policy.

PURPOSE

To establish the process by which members with tuberculosis (TB) are identified andreferred for Direct Observation Therapy services.

DEFINITION:

DOT is a technique requiring public health staff to assist members who are unwillingand/or unable and to follow their treatment regime and observe the ingestion of prescribed medications to treat TB disease.

DOT services are available through local health department (LHD). TB Control Programs are excluded as a covered benefit (i.e. "carved-out") under Health Plan Medi-Cal contracts with the California Department of Health Services. IHHMG acknowledges the provisions of MMCD Policy Letter No. 97-05, and coordinates DOT referrals with TB Control Programs for all members. IHHMG will collaborate with local TB Control Programs to identify members who must and/or should be referred for DOT services.

POLICY

It is the policy of IHHMG to protect the health of the public by assuring that the entire courseof tuberculosis treatment medication is taken by patients in the correct dose, at the correct

time, and for the complete period of therapy, Direct Observation Therapy (DOT) is ameasure employed to protect the health of the public.

PROCEDURE

1. PCPs are responsible to act as the primary care manager for the member, and submitthe required report to the LHD, and make referrals to the TB Control program if a member has been identified as a mandatory and/or possible candidate for DOT.

2. Each PCP is responsible for reporting to the LHD, within the specific timetable as found in Health and Safety Code Section 121361 & 121362. The reporting of confirmed or suspected TB disease must occur within one working day of diagnosis.

3. The information reportable to the LHD includes:

4. Member demographics

    4.1. Member name

    4.2. Address

    4.3. Home telephone number

    4.4. Date of birth

    4.5. Gender

    4.6. Ethnicity

    4.7. Marital status

5. Locating Information

    5.1. Employer

    5.2. Work address and phone number

6. Disease information

    6.1. Disease diagnosed

    6.2. Date of onset

6.3. Symptoms

6.4. Laboratory results

6.5. Medications prescribed

7. The PCP will ensure that appropriate and accurate documentation is recorded inthe member's medical record.

Follow-up Care

I. The PCP coordinates with the LHD TB Control Office and provides follow-up care toall members receiving DOT services.

2. The PCP informs the LHD TB Control Program's Nurse Manager of any changes in amember's response to treatment or drug therapy.

3. The PCP provides education to the member regarding the LHD DOT treatment plan.

4. The PCP will receive a monthly report from the LHD TB Control Program's NurseManager to advise the PCP of each member's treatment status.

5. Upon completion of DOT services, the LHD will fax a copy of the member's medicalrecord and final status report to the PCP.

6. The PCP will be responsible to schedule the member for a follow-up appointment inorder to develop a follow-up treatment plan.

7. The responsible clinic staff will either call or mail the appointment schedule slip to themember.

8. If the member is a "no show" for the scheduled follow-up appointment, the PCP willfollow up via phone call or letter.

8.1. If there is no response, the PCP will notify the local TB Control Office.

Members' Risk for Non-Compliance for TB Treatment

1. Members with demonstrated multiple drug resistance

1.1 To Isoniazid

1.2 To Rifampin

2. Members whose treatment has failed or who relapses after completing a prior regimen

3. Children and adolescents

4. Individuals who have demonstrated non-compliance

4.1 Members who failed to keep office appointments

5. The PCP will refer members with active TB and who have any of these risks to the TBControl Officer of the LHD for DOT

Members for Potential Non-compliance and for Consideration for DOT

I. The PCP will assess the following

1.1 Substance abusers

1.2 Members with mental illness

1.3 The elderly

1.4 Members with unmet housing needs

1.5 Members with language and/or cultural barriers

2. If, in the opinion of the PCP that a member with one or more of these risk for non-•compliance, the member will be referred to the LHD for DOT.

Case Management Plan

1. All suspected TB cases are referred to the appropriate health plan to ensure coordination of care, appropriate utilization, and timely delivery of quality medicalcare.

1.1 The health plan's health services staff communicate with the local TB ControlProgram and PCPs concerning these cases.

2. When requested by the PCP or the local TB Control Program, the appropriate healthplan staff will provide assistance with the coordination of the member's care.

3. The PCP and/or case manager may contact the appropriate health plan to requestassistance with locating members who are repeated "no-shows" for appointments.

3.1 If the member cannot be contacted, the health plan will be responsible for notifying the PCP and the LHD in accordance with California Health and Safety Code, Section 121362.

4. All cases referred to the health plan by a PCP are managed according to the healthplan's care management procedures.

4.1 The Health Services Care Managers analyze data, assess the member's needs, identify potential interventions and implement interventions with the member, thefamily and the health care team, within the limits of confidentiality.

Reference(s)
MMCD Policy Letter No. 97-05

Health and Safety Code Section 121361 & 121362
California Health and Safety Code, Section 121362.

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Therapeutic Formula - Infants	
Policy Number(s): 10-031	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP's, and Specialist's, and Providers shall follow the procedures set forth in this policy.

PURPOSE

The purpose of this policy is to ensure a clear understanding of the authorization and UMprocess in the provision of therapeutic formula.

Medi-Cal Managed Care Division (MMCD) Policy Letter 07006, dated April 2, 2007, clarified contractual requirements for Medi-Cal managed care health plans for providing medically necessary therapeutic enteral formulas as a covered Medi-Cal benefit for **infants and children below 12 years of age.**

DEFINITION

A therapeutic "medical" food is one that is formulated to be consumed or administeredunder the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation (21 U.S.C. 360ee(b)(3)). Therapeutic formula feedings used to boost normalgrowth and development in certain infants and children or to prevent serious disability and death may be administered orally or by means of an enteral feeding tube.

POLICY

It is the policy of the IHHMG Utilization management department that its authorizationprocedures and review for approval of therapeutic enteral formulas shall be supervised by qualified healthcare professionals, and denials shall be reviewed by a qualified physician.

PROCEDURE

Decisions and reconsideration/appeals regarding therapeutic enteral formula shall be performed in a timely manner based on the sensitivity of medical conditions and rendered as:

1. Emergency requests: in no event shall prior authorization be required when there is a bonafide emergency requiring immediate treatment (Welfare and Institutions Code Section 14103.6);

2. Expedited requests: within three (3) working days for services that a provider or a plan determines that following the standard timeframe could seriously jeopardize the member'slife or health or ability to attain, maintain, or regain maximum function;

3. Non-emergency requests: within five (5) working days when proposed treatment meetsobjective medical criteria, and is not contraindicated; and

4. Regimen already in place: within five (5) working days for review of a currently provided regimen as consistent with urgency of the member's medical condition (Health and SafetyCode Section 1367.01);

5. Any decision on therapeutic enteral formula that is delayed beyond these time periods areconsidered an approval and must be immediately processed as such;

WIC REFERRALS:

Referrals to Women, Infants and Children's (WIC) Program

- Members should ***not*** be referred to WIC for therapeutic enteral formulas because WIC does not receive funding to supply these products or the accompanying servicesfor ongoing evaluation of medical conditions;

Review and Authorization:

Authorization and approval criteria for providing therapeutic enteral formulas shall be based upon current sound medical evidence and/or clinical best practice guidelines, such as Medi-Cal coverage and medical necessity criteria, MCG, and Health Plan guidelines.

Criteria Review & Updates

A system for consistent application of medical necessity criteria for therapeutic enteral formulafor specific medical conditions:

- Criteria are review and updated at least annually

Evaluation: Failure to Thrive infants (FTT)

IHHMG shall collaborate with the member's health plan, State and County Health Agencies and local community agencies to evaluate social and environmental conditions related to Failure to Thrive Infants, such as "Children's Protective Services".

NEW MEMBERS CURRENTLY RECEIVING THERAPEUTIC FORMULA:

An adequate time period for new members to continue receiving current therapeutic formularegimen not to exceed 120 days.

Additional requests beyond this period would require clear /current re-evaluationdocumentation report of clinical indications for continued therapy.

Reference(s)

Title 22 California Code of Regulations (CCR)
51313.3(e)(2))MMCD Policy Letter 07-016

Attachments:

MMCDPL07016
ENTERAL FORMULA.

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Women, Infants, and Children (WIC) Program	
Policy Number(s): 10-032	**Orig. Date:** 05/01/16
Effective Date: 07/07/21	**Revision(s) Date:** 07/07/21
MSC Committee Approval: **Date:** 07/29/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 07/29/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE
Imperial Health Holdings Medical Group Utilization Management Staff, PCP's, and Specialist's shall follow the procedures set forth in this policy.

PURPOSE
The purpose of this policy is to provide clarification on the necessary medical information needed when referring pregnant, post-partum/breastfeeding women and children up to 5 years to Women, Infants, and Children (WIC) as mandated by Title 42, CFR 431.635(c).

POLICY
Eligible families will be referred to WIC. Eligible families include those with low to moderate incomes (living at or below 185% of Federal Poverty Level) or who receive Medi-Cal, Cal Works or CalFresh and who are:

- Pregnant women
- Breastfeeding women up to one year and non-breastfeeding women up to 6 months, after delivery (including recent pregnancy loss)
- Infants and children from birth up to five years*
- Dads, grandparents, foster parents or guardians who care for eligible children
- Working, military and migrant families

* Most infants and children under 5 years of age that receive CHDP health assessments also participate in the WIC program.

PROCEDURE

To refer their patients to WIC, PCP's and Specialists can complete the appropriate referral form with the required medical information listed below. The forms are available on the CA Department of Public Health (CDPH) at https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/HealthCareProviders.aspx

Medical record documentation required when completing the Pediatric WIC Referral Form*:

- Patient's information (name, DOB, etc.)
- Current height/length (ins.)
- Current weight (lb. oz.)
- Current BMI percentile
- Date of measurements
- Birth Weight (lb. oz.) / Length (ins.)
- Hgb or HCT test (required annually and every 6 months if abnormal)
- Blood test date
- Lead test
- Immunization status
- Breastfeeding assessment

Medical record documentation required when completing the Pregnant Women WIC Referral Form:

- Patient's information (name, DOB, contact information)
- Current height (ins.)
- Current weight (lbs.)
- Date of measurements
- Hgb or HCT
- Blood test date
- Estimated due date
- Medical conditions
- Currently prescribed medications/supplements

Medical record documentation required when completing the Post-Partum / Breastfeeding Women Referral Form

- Patient's information (name, DOB, contact information)
- Current height (ins.)
- Current weight (lbs.)
- Date of measurements
- Hgb or HCT
- Blood test date
- Pregnancy Outcome
- Medical conditions
- Currently prescribed medications/supplements

Reference(s)
Title 42, CFR 431.635(c).

Department of Public Health (CDPH)

www.wicworks.ca.gov

Attachments:

WIC POLICY LETTER.pdf

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Long Term Care	
Policy Number(s): 10-033	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP's, and Specialist's,and Providers shall follow the procedures set forth in this policy.

PURPOSE

To establish a process by which Medi-cal members are identified and referred to Long Term Care and ensures that members in need of nursing facility services are placed in a health care facility that provides the level of care most appropriate to the member's medical needs.

POLICY

It is the policy of IHHMG that its Medi-Cal members in need of extended care nursing facility services are placed in facilities providing the appropriate level of care commensurate with theirmedical needs. When members require such care for longer than the month of admission plusone month, the health plan coordinates the member's disenrollment and transfer of care to theMedi-Cal Fee-For-Service (FFS) system.

If the health plan does not contract with an appropriate Medi-Cal approved long-term care facility, the health plan ensures that the member is transferred to a Medi-Cal approved facility.

PROCEDURE

1. **Identification**
   1.1. The health plan Medi-Cal members requiring Long Term Care ("LTC") may

beidentified in one of four ways:

1.1.1. Physician Identification - The member's primary care physician ("PCP") orspecialist conducts a comprehensive history and physical assessment of themember and identifies him/her as a potential LTC patient.

1.1.2. Care Management/Concurrent Review – Case Management (if delegated) Concurrent Review Nurses review daily census reports that identify members ininstitutional settings.

1.1.3. Claims Receipt - If the health plan is not notified of a possible LTC candidate by one of the above two processes, the health plan is notified of the candidate when aclaim for services is submitted to the Claims Department for retroactive authorization and payment.

1.1.4. Other sources of identification include, but are not limited to: specialty care physicians, social workers, discharge planners and other health care providersinvolved in the member's care.

2. Long Term Care Patient Selection Criteria

2.1. Criteria for LTC eligibility shall be based on intensity of service and severity of illness.

2.2. Each case is evaluated based on the following criteria: PCP diagnosis and treatmentrecommendations, facility health care team assessment, Title 22 Chapter 8 Article 1,and the Minimum Data Set (MDS) at 7 and 14-day intervals

2.3. The health plan's contracting PCPs or specialists assess member's needs to determineappropriate level of service prior to the request for admission to LTC.

2.4. A member may be admitted to any of the following levels of LTC facilities if the PCP orSpecialist determines the member meets the admission criteria:

2.4.1. Transitional Care (TC)

2.4.2. Intermediate Care Facility (ICF)

2.4.3. Subacute Care Facility

2.4.4. Rehabilitative Care

2.4.5. Facility Skilled Nursing

2.4.6. Facility (SNF)

2.4.7. Short Term Care

2.4.8. Long Term Care

2.4.9. Custodial Care

2.5. If the member does not meet the criteria for an admission to LTC, the member continues to receive coordinated case management until the treatment is completed.

3. Coordination of Care

3.1. The member's PCP continues to provide care for the member during the initial transition to LTC. The PCP communicates with the LTC attending physician to ensurecontinuity of care. This step includes forwarding all pertinent records to the new PCP when identified.

3.2. When a member has been identified as a potential candidate for Long Term Care, the health plan's Health Services staff monitors that the member is admitted to a Medi-Calapproved LTC facility and submits a request for disenrollment from Health Net throughits Medi-Cal Member Services Department.

4. Disenrollment

4.1. The health plan shall ensure that the dis-enrollment documents are sent to the Department of Health Care Services (DHCS) Health Care Options (HCO) enrollmentcontractor for review and dis-enrollment.

4.2. Disenrollment Approved

4.2.1. The member is dis-enrolled from the health plan when approval is received from HCO. An approved disenrollment request becomes effective the first day of the second month following the month of the member's admission to the LTC facility, provided that the disenrollment request was submitted at least 30 days prior to thatdate.

4.2.2. The Medi-Cal Member Services Department notifies the Health Services staff ofthe member's disenrollment. This prompts the LTC facility to forward MC171 formto DHCS.

4.2.3. All medically necessary services provided to the member are covered andcoordinated by the health plan until the disenrollment process is complete.

Reference(s)

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATIVE SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Major Organ Transplant Services (except for kidney transplants)	
Policy Number(s): 10-034	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:** 09/01/19
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ **IHP** ☒ **IHHMG** ☒ **IICT**	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP's, and Specialist's, andProviders shall follow the procedures set forth in this policy.

PURPOSE

The purpose of this policy is to evidence a clear procedure for managing requests for authorization formajor organ transplant evaluations and transplants for the IHHMG Medi-Cal membership.

POLICY

IHHMG follows the Medi-Cal Advisory Committee on Anatomical Transplant (MACAT) selection criteriawhen reviewing all pre-transplant evaluation requests as stated in MMCD Policy Letter 97-07.

The following major organ transplants are not covered services under IHHMG's scope of financialresponsibility.

- Bone Marrow Transplantation
- Cardiac Transplantation
- Liver Transplantation
- Cardiac/Lung Transplantation (combined)
- Liver/Kidney Transplantation (combined)
- Liver/Small Bowel Transplantation (combined)
- Small Bowels Transplants

Final authorization of major organ transplants is the responsibility of the Medi-Cal field office (for adults)and for children under 21 years of age, the California Children Services (CCS) central office.

PROCEDURE

When a Member is identified as a potential major organ transplant candidate, IPA /Plan shallrefer the Member to a Medi-Cal approved transplant center.

Participating IHHMG PCPs/Specialists perform diagnostic evaluations, including referrals toappropriate specialists, to ascertain if a patient/participant/client is a potential transplant candidate.

All referral authorization requests for organ transplant evaluations/transplants shall be reviewedby the IHHMG UM Medical Director.

The Clinical Services team will:

a) Issue the pend/deferral letter if clinical information is missing
b) Advise members regarding the use of Centers of Medical Excellence
c) Issue denial letters for benefit limitation
d) Document concurrent review, discharge planning and member needs
e) Coordinates the care for the member and communicate with Anthem Transplant CaseManagement Department
f) Notify approval for the actual transplant and the transplant admission after medical review bythe Health Plan
g) Provide referrals and authorizations for all pre and post-transplant services
h) Notify the health plan Transplant Case Management of any issues for assistance
i) Notify the health plan Transplant Case Management Department of all transplant relatedadmissions within 2 business days.

The potential transplant cases NOT DELEGATED to IHHMG will be submitted to the HealthPlan's Utilization Management Department for management, review and approval.

IHHMG will notify the Health Plan of any potential transplant or transplant evaluation NOT DELEGATED to IHHMG, within 1 business day of receipt of the request (even when in testing/evaluation phase) to determine Centers of Medical Excellence/Plan approved Transplant Centernetwork use.

Participating PCPs continue to be responsible for primary care and coordination of services during the transplant evaluation and transition period, including the transfer of all medical records to the transplant physician to ensure continuity of care, until the patient/participant/clientis dis-enrolled from the plan

If the Medi-Cal approved transplant center deems the patient/participant/client a suitable transplant candidate, the center information the Nurse and the PCP / Specialist submit a priorauthorization request, with appropriate medical documentation, to one of the following offices:

- For members age 21 years and older, major organ transplant authorization requests,except kidney and cornea, must be sent to:

  San Francisco Medi-Cal Field
  Office185 Berry Street, Suite
  290
  San Francisco, CA
  94107415-904-9600

- For members under 21 years of age, all major organ transplantation authorizationrequests, except kidney, must be sent to: CCS-

  Children's Medical
  ServicesCentral Office
  714 P Street, Room 350
  PO Box 942732
  Sacramento, CA 94234-7320
  916-654-0499

- Members ages 21 years or older with a Genetically Handicapped Persons Program (GHPP) eligible condition have their eligibility for major organ transplants determined inthe same manner as all other adult enrollees, except that the GHP (not the San Francisco Medi-Cal Field Office) approved the transplant authorization request.

- GHPP eligible conditions include:

  - Hemophilia
  - Cystic Fibrosis
  - Hemoglobinopathies, including sickle cells disease and thalassemia
  - Huntington's Disease; Joseph's Disease, Friedreich's Ataxia

- Metabolic diseases (PKU, Wilson's Disease, galactosemia, etc.)
- Von Hippel-Lindau syndrome

- On approval for transplant, the patient/participant/client is dis-enrolled.
- All GHPP – related matters should be addresses to:

Genetically Handicapped Persons
Program715 P Street, Room 300
PO Box 942732
Sacramento, CA 94234-7320
916-654-0503

IHHMG remains responsible for the provision of primary care services and for coordination of care withCCS regarding rental transplant services. Please refer to the Policy and Procedure title, "California Children Services."

Reference(s)
MMCD Policy Letter 97-07.

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATIVE SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Standing Referrals	
Policy Number(s): 10-035	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:** 09/01/19
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP's, Specialist's, and Providers shall follow the procedures set forth in this policy.

PURPOSE

The purpose of this policy is to define the process for Standing Referrals for Medi-Cal members.

POLICY

This policy applies to members who require specialized care over a prolonged period for a life-threatening, degenerative or disabling condition, including human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS).

IHHMG authorizes standing referrals to specialists who have the expertise in treating thecondition or disease. The specialist shall coordinate the member's health care.

When authorizing a standing referral for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, the specialist must meet California Health and Safety Code criteria as an HIV/AIDS specialist.

PROCEDURE

1. A standing referral request for in network or out of network provider shall be documented on a Prior Authorization Request form by the PCP after consultation with the specialist orspecialty care center.
2. The PCP, specialist and designated physician determines that continuing care from a specialist is needed and referrals are made based on an agreed upon treatment plan, if

any. Treatment plans may limit the number of specialist visits or the length of time the visitsare authorized, and may require the specialist to make regular reports to the PCP.

3. After receiving standing referral approval, the specialist is authorized to provide healthcareservices that are within the specialist's area of expertise and training to the member in thesame manner as the PCP.

4. The PCP must refer to an out-of-network specialist if one is not available within theProvider Organization who can provide appropriate specialty care to the member.

5. IHHMG, Utilization Management department must make a determination on the request fora standing referral within three (3) business days (business days are Monday through Friday). Once a standing referral is in place, the member will not need permission or prior authorization for each visit with the specialist.

6. If authorized, the actual referral (notification) will be made within 4 business days of the date and the proposed treatment plan, if any, is submitted to the designated physician (e.g.,Medical Director).

7. The UM Review Nurse evaluates incoming standing referral requests for compliance withthe guidelines stated in this policy.

   7.1. S/he will aauthorize the standing referral when the information received with the requests supports the appropriateness of a standing referral. If the need for a standing referral is not supported by the information received with the request, immediately forward the request and supporting documentation to the Medical Director/designee forevaluation.

   7.2. S/he will assist the Medical Director/designee as needed with arranging a conference with the PCP and the current or planned specialist/specialty care center to discuss thepatient's needs and develop a treatment plan.

   7.3. S/he will notify the Disease Management Nurse (IF DELEGATED) or the Health Plan'sDisease Management Nurse when

      7.3.1. Member's condition has exacerbated since last review

      7.3.2. Member has a high-risk condition that can benefit from case managementintervention

Reference(s)

AB 2168 (Chapter 426, Statutes of 2000) - AB 2168 adds language to existing statutespecifying that Human Immunodeficiency Virus (HIV) positive and Acquired Immune Deficiency Syndrome (AIDS) patients are eligible for standing referrals. A "standing referral" means a referral by a primary care physician to a specialist for

more than one visit, without the primary care physician having to provide a specific referral for each visit. AB 2168 will require HCSPs to authorize standing referrals to providers or clinicswith recognized experience in treating HIV and AIDS when medically necessary.

(Amends, adds, and repeals Section 1374.16 of the Health and Safety Code, relating to health care.)

A Standing Referral may be provided for care of Chronic Diseases such as Diabetes or Asthma

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATIVE SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Ensuring Timely Access to Confidential and Sensitive Services	
Policy Number(s): 10-036	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** **03/25/21**	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** **03/25/21**
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP's, and Specialist's, and Providers shall follow the procedures set forth in this policy.

PURPOSE

To ensure timely and confidential access to sensitive and preventive services.

POLICY

It is the policy of IHHMG to timely and confidential medical access regarding sensitive and preventive services.

Definition

Sensitive and Prevention Services include family planning services and pregnancy services, including pregnancy termination; sexual assault; diagnosis, ensuring access to transgender services, per Health and Safety Code, Section 152; 1367.63 and treatment of sexually transmitted diseases; HIV counseling, testing and treatment; alcohol and/or substance abuse services; and outpatient behavioral health counseling and treatment.

Confidential information includes specific facts or documents identified as "confidential" by law,regulations, or contractual language. Confidential member information includes any individually identifiable information about an individual's character, habits, avocation, occupation, finances, credit, reputation, health, medical history, mental or physical condition

ortreatment. Confidential information obtained in either a casual or formal setting, including conversation, computer screen data, faxes, and/or any written form.

PROCEDURE

1. Services are provided in confidence to adolescents and adults from any qualified providerin a timely manner without barriers including prior authorizations.

    1.1. Adult members may self-refer without prior approval except in cases where thoseservices require hospitalization.

2. Adolescents twelve (12) years of age and older may request these services withoutparental consent.

3. Parents and/or guardians will not be informed of a minor's sensitive services informationwithout the minor's permission, except as allowed by law.

4. Adolescent and adult members are able to access the following services in a timely andconfidential manner without prior authorization:

    4.1. Family planning services.

        4.1.1. Coordination of care is defined in the IHHMG Policy and Procedure FamilyPlanning Program Services.

    4.2. Pregnancy services (including pregnancy termination).

        4.2.1. Specific pregnancy care requirements are referred in the IHHMG Policy andProcedure Perinatal Care.

    4.3. Treatment for injuries resulting from sexual assault.

    4.4. Diagnosis and treatment of sexually transmitted diseases from any qualified provider.

        4.4.1. Coordination of services refer to IHHMG Policy and Procedure SexuallyTransmitted Disease (STD) Services,

        4.4.2. Reimbursement for services related to sexually transmitted infections asreferred to IHHMG Policy and Procedure Sexually Transmitted Diseases Reimbursement.

    4.5. HIV counseling and testing services

        4.5.1. Confidential or anonymous HIV counseling and testing services from any qualified a provider. The IHHMG Policy and Procedure HIV Testing and

Counseling which describes the coordination of and reimbursement for services.

4.6. Alcohol and substance abuse treatment, including heroin detoxification, confidentialreferrals.

4.6.1. IHHMG Policy and Procedure Alcohol and Drug Treatment Services discussesthe coordination of care for a member requiring Alcohol and/or substance abuse treatment.

4.7. Behavioral health referrals.

4.7.1. The coordination of Behavioral health services shall be coordinated by IHHMGUM staff. The member shall be referred the Plan's BH Providers or the California Department of Mental Health specific to the member's County of residence.

5. Members should call their in-plan Primary Care Provider (PCP) to schedule an appointmentfor the following:

5.1.1. Medical care according to the nature of the medical problem. Medical problemsmay be routine, urgent, or emergent. The member and/or participating primary care provider (PCP) should make the determination of timely access.

5.1.2. Sensitive and prevention services, and education regarding positive impact ofcoordinated care on health outcomes.

5.1.3. Confidential referrals from their PCP for family planning services, and pregnancy services, including pregnancy termination; sexual assault services; sexually transmitted diseases and treatment; and HIV counseling and testing, alcohol and/orsubstance abuse treatment; and behavioral health treatment.

6. A member desiring a referral to an out-of-plan provider for sensitive and preventionservices should call that provider to schedule an appointment.

6.1. Out of plan providers must demonstrate reasonable efforts to coordinate services withthe member's PCP, or obtain a refusal to do so from the member.

6.2. members should be encouraged to return to their PCP for continuity of care.

6.3. Adolescents twelve (12) years of age and older may requests these services withoutparental consent.

6.4. Limitations on Services (Out of Plan Providers)

6.4.1. There are limitations of coverage for family planning, sexually

transmitteddiseases and HIV services.

6.4.2. Coverage and limitations are described in the Health Plans' Evidence ofCoverage (EOC) manuals

7. The member receives all health care services and claims processing services withconfidentiality assured.

7.1. IHHMG employees and contracted physicians respect each member's right to confidentiality and treatment information in a respectful and professional mannerconsistent with all applicable Federal and State requirements.

7.1.1. Discussion of member's information should be limited to that which is necessaryto perform the duties of the job.

Reference(s)

http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL1998/MMCDPL98011.pdf

Attachments:

05-006 FAMILY PLANNING.docx

IMPERIAL MANAGEMENT
ADMINISTRATIVE SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: HIV Testing and Counseling	
Policy Number(s): 10-037	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ **IHP** ☒ **IHHMG** ☒ **IICT**	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP's, and Specialist's, and Providers shall follow the procedures set forth in this policy.

PURPOSE

To ensure that the P/P/C's confidentiality is maintained; that the services are rendered by a Disease appropriate and qualified practitioner; and the claims are processed and submitted in accordance with program, health plan and financial class considerations.

POLICY

IHHMG members' access to appropriate and confidential HIV testing and counseling services form an HIV and AIDS knowledgeable and qualified practitioner. IHHMG will process disease claims in accordance with the health plan program requirements and regulatory agency standards.

PROCEDURE

1. The member may access confidential HIV testing, follow-up, and counseling services bycalling their Primary Care Physician's office and scheduling an appointment.

   1.1. Members are exempt from prior authorization for HIV testing and/or counseling.

2. Members receiving services are entitled to full consideration of privacy and confidentialityconcerning the following, but not limited to

2.1. Verbal and/or written communications

2.2. Medical records

2.3. Case discussion

2.4. Consultation

2.5. Examination/evaluation

2.6. Treatment and services

3. Written authorization from the member or the member's authorized legal representativemust be obtained in accordance with HIPPA regulations prior to the release of medical records,

4. A knowledgeable and qualified practitioner will perform the following on the member's initialvisit

4.1. Pre-test counseling services.

4.2. A complete history and physical

4.3. Necessary and required laboratory work-up

5. Member's diagnosed with HIV receive follow-up care and counseling.

5.1. The Primary Care Physician (PCP) is responsible for offering HIV testing, counseling, and education to parents or legal guardians, infants, children, and Adolescents in thefollowing categories in accordance with MMCD Policy Letter # 97-08

5.1.1.1. Infants and children of HIV seropositive mothers

5.1.1.2. Infants and children of mothers at high risk for HIV infection with unknownHIV serologic status

5.1.1.3. Adolescents who engage in high risk behaviors (unprotected sex and/orillicit drug use)

5.1.1.4. Children receiving blood transfusion/blood products between 1977 and1985

5.1.1.5. Other children deemed at high risk by the PCP

6. Children and adolescents who are confirmed HIV positive are eligible for California ChildrenServices (CCS).

   6.1. The PCP will refer the member to CCS when identified.

   6.2. It is the PCP's responsibility to communicate with CCS and the CCS paneledpractitioner to coordinate the member's care.

   6.3. The PCP is responsible for providing primary care services, including referring and coordinating necessary specialty care not related the member's CCS eligible condition.

Reference(s)

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATIVE SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Treatment Plan and Specialists Follow-up Visits	
Policy Number(s): 10-038	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ **IHP** ☒ **IHHMG** ☒ **IICT**	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP, and Specialist shall follow the procedures set forth in this policy.

PURPOSE

To ensure an appropriate treatment plan and plan of care for the member

POLICY

The PCP, specialist and designated physician determines that continuing care from a specialist is needed.

PROCEDURE

The referrals are made based on an agreed upon treatment plan, if any. Treatment plans may limit the number of specialist visits or the length of time the visits are authorized, and may require the specialist to make regular reports to the PCP.

The PCP shall manage the treatment plan of the member and coordinate care and services as needed for the member

Reference(s)
[CA Health & Safety Code 1374.16(a)]

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Acupuncture	
Policy Number(s): 10-039	**Orig. Date:** 01/01/20
Effective Date: 01/01/20	**Revision(s) Date:**
MSC Committee Approval: **Date:** **03/25/21**	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** **03/25/21**
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP, and Specialist shall follow the procedures set forth in this policy.

PURPOSE

This policy is to ensure acupuncture services are provided to MediCal members in accordance with APL16-015. IHHMG complies with all applicable state and federal law and regulations and other contract requirements as well as Department of Health Care Services' guidance.

POLICY

It is the policy of IHHMG to provide coverage and reimbursement for acupuncture services, subject to program and eligibility requirements (APL 16-015 – attached).

PROCEDURE

IHHMG will ensure timely processing, according to regulatory guidelines, of requested Acupuncture services based on the following:

- Acupuncture services are covered to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. Outpatient acupuncture services (with or without electric stimulation of the needles) are limited to two services in any one calendar month per the Medi-Service reservation limitation (California Code of Regulations, Title 22, Section 51304[a]), although additional services can be provided based upon medical necessity through the IHHMG prior authorization process.

- There is no frequency limitation for beneficiaries receiving services through the Early and Periodic Screening, Diagnosis, & Treatment program. Acupuncture services are reimbursable using Current Procedural Terminology-4 procedure codes 97810, 97811, 97813 or 97814 when

rendered by a physician, dentist, podiatrist or certified acupuncturist 4 who is eligible to provide Medi-Cal services.

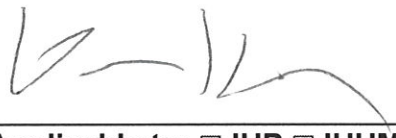
Reference(s)

Attachments:

APL16-015
ACUPUNCTURE.pdf

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Case Management – Transition of Care	
Policy Number(s): 10-040	**Orig. Date:** 06/13/16
Effective Date: 06/13/16	**Revision(s) Date:**
MSC Committee Approval: **Date:**  **03/25/21**	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: **Date:** Josie Wong **03/25/21**
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group shall follow the procedures set forth in this policy.

PURPOSE

To improve continuity and coordination of medical care.

POLICY

When delegated, the organization will analyze and measure its performance on managing all care transitions as well as identifying and acting on opportunities to improve continuity and coordination of care.

Definitions:

Care Setting- The provider or place from which the member receives health care and health-related services. Settings include: home, home health care, acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility.

Transition- Movement of a member from one care setting to another as the members' health status changes.

- Planned Transitions- include elective surgery or a decision to enter a long-termfacility.

Transitional Process- The period from identifying a member who is at risk for a care transition through the completion of a transition. This process goes beyond the actual movement from one setting to another; it includes planning and preparation for transitions and the follow-up care after transitions are completed.

Un-planned Transition- An unintended event such as an emergency hospitalization or placement into a skilled nursing facility or alternate living arrangement that is unplanned.

Care Plan- A set of information about the patient that facilitates communication, collaboration and continuity of care across settings. The organization sets parameters for the types of information that should be communicated between settings in a care plan. The care plan should be tailored to each individual and take patient health status into consideration. The care plan may contain, and is not limited to, both medical and non- medical information.

PROCEDURE

A. Notification between Settings:

1. Planned and Unplanned transitions from any setting to any other setting are identified by a notification that is achieved through fax, verbal, or secure e- mail. This information is then documented in a daily census, listing each individual member that has undergone a care transition to an acute hospital, skilled nursing facility, or rehabilitation center. The daily census automatically populates from an authorization report within one business dayof notification of the admission.

   a. The UM/Case Management team has established procedures for working with network facilities to identify members who experience unplanned transitions such as hospitalizations through the Emergency Department or admissions to Long Term CareFacilities.

   b. In network acute care facilities are expected to send hospital admissions informationto the organization by faxing the hospital face sheet and clinical information to the
   UM Department within one (1) business day of admission.

   c. In network long-term facilities are expected to send report of admission to organization by faxing the facility's face sheet and clinical information to the UMDepartment within one business day of admission.

2. For planned and unplanned transitions from members' usual setting of care to the hospital and transitions from hospital to the next setting, the UM department designatedstaff will coordinate sharing, the sending setting's care plan with the receiving setting within one business day of notification of the transition

3. The member or responsible party will be notified of the transition, changes to the member's health and plan of care within two business days. For planned and

unplannedtransitions from any setting to any other setting the member's usual practitioner will be notified of the transition within three business days or as directed by contracted health plan.

B. Supporting Members Through Transition:

1. For planned and unplanned transitions from any setting to any other setting the Care Transition Team will communicate with the member or responsible party about the transition Process and about changes to the member health status andplan of care.

2. All members meeting the above criteria will be provided with a name and phone number of a Case Management designated staff who is responsible for supporting the member through the transition process. A member of the Case Management Team will accomplish the above communications with either the either the memberor responsible party within three business days of the transition.

3. Organization's case manager or designated transition staff will collaborate with member's case manager of another plan, if applicable. This may occur when the member transfers or changes to another health plan in the middle of his/her
care. Organization's case manager will share clinical information as requested in accordance with organization's compliance standards.

C. Reducing Transitions:

1. The Case Management Team is committed to minimize unplanned transition andprevent avoidable transitions across its member population by:

a. Readmission Report (weekly)
b. Catastrophic Report (weekly)
c. High Risk Report (monthly)
d. Disease Management Enrollment Report(monthly)
e. Admit utilization report(monthly)
f. Transition PCP follow-up appointment reporting for continuity of care(at least weekly).
g. Emergency Room Reporting (weekly)

2. If any one of the following diagnosis/claim or encounter is identified then classify asHigh-Risk.

a. AIDS Diagnoses
b. ESRD Diagnoses
c. Behavioral Health Diagnosis with concurrent chronic medical condition
d. Recent Organ Transplant
e. Cancer currently being treated
f. Hospitalization within last 60 days

g. 3 or more hospitalizations in last 12 months
h. 3 or more Emergency Room visits in last 12 months

4. Members may also be identified as having increased risk for unplanned transitions bynotification from a number of sources such as:

   a. Health Plan/IPA/PPG Case Managers and Social Workers through directmember interaction
   b. Primary Care Physicians and Specialty Providers.
   c. Member Services Department
   d. Disease Management Department

D. Action to Provide Improvement in Care coordination

1. By utilizing the monthly data results, the organization ensures unplanned transitions areminimized and works to maintain members in the least restrictive setting possible by performing the following processes.

   a. Conduct quantitative and causal analysis of data to identify continuity of careimprovement opportunities.
   b. Coordinating services for members at high risk of having a transition.
   c. Educating members or responsible parties about transitions and how to preventunplanned transitions.
   d. Analyzing monthly discharge reports.
   e. Monthly Hospital utilization Reports.
   f. Annual review of Complex Care Program and results from report analysis.
   - Construct revised program for the following year that reflectsthe updated identified opportunities for improvement.

2. The interventions identified for improvement will be re-measured for performancedetermination at least annually

Reference(s)
NCQA Standard and Guidelines
CMS Managed Care Manual

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Complex Case Management - Development of an Individualized Case Management Plan	
Policy Number(s): 10-041	**Orig. Date:** 06/13/16
Effective Date: 06/13/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ **IHP** ☒ **IHHMG** ☒ **IICT**	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group shall follow the procedures set forth in this policy.

PURPOSE

To provide a systematic and collaborative approach to the identification, comprehensive care coordination and management of members with complex or serious medical conditions who may benefit from Case Management services.

POLICY

IHHMG Case Managers identify and coordinate comprehensive care and management formembers with complex or serious medical conditions.

PROCEDURE

1. Complex Case Management is a process directed at the personalized coordination and integration of resources utilized to create cost-effective options for catastrophically ill or injured members on a case by case basis. The aim is to use available resources in the most effective manner to facilitate quality treatment goals.

2. Case Managers are RNs licensed i the state of California
    a. The staffing ratio is 50 active cases per CM
        i. This includes a mix of cases in the:
            1. Assessment phase
            2. Actively managing phase

3. Ready for discharge phase

3. Members who may be appropriate for case management include, but are not limitedto. Those members with or at risk for:
    a. Complex or catastrophic medical conditions or diagnosis.
    b. Chronic Diseases, Conditions or illnesses

4. The Complex Case Management Program includes, but is not limited to:
    a. Standardized identification of High Risk Members.
    b. Referral processes
    c. Triage mechanisms with appropriate time frames
    d. Comprehensive assessment processes and formats.
    e. Individualized Care plan development and implementation of guidelines.
    f. Coordination of carve-out services.
    g. Documentation and communication processes for all services.
    h. Mechanism for evaluation of Complex Case Management outcomes.
    i. Mechanism for identification and referral of quality of care issues to theQuality Improvement department.

5. Referrals for Case Management follow a systematic, objective screening processusing established guidelines/criteria of all members referred for services.

6. Screening - Upon receipt of a referral the CM Coordinator determines individualeligibility and refers the case to the Case Manager (CM).

7. The CM conducts a preliminary screening, utilizing the electronic survey/assessment-screening tool to determine if the member is appropriate for CMservices.
    a. First level screening includes a brief review:
        i. Diagnosis and medical information including co-morbidities
        ii. Demographic information
        iii. Authorization history, claims data , lab data, and/or available medicalrecords
        iv. Available pertinent information related to the member's psychosocial,home environment, status of available and competent caregiver, andfunctional status.
        v. Completion of survey/assessment screening tool for specific chronicconditions.
    b. The member is appropriate for CM assessment if the screening outcomeindicates the member will benefit from CM services.

8. Upon determination that a member is appropriate, the CM provides a description ofservices to the member or authorized representative.

9. CM provides the member or authorized representative of their rights, choices andresponsibilities, including but not limited to:
    a. Right to privacy and confidentiality

b. Right to expect personally identifying information shall be released inaccordance with federal and state law.
c. Right to be treated courteously, fairly and with dignity and respect.
d. Right to appeal actions
e. Right to Consent
f. Right to refuse services with no impact on available benefits
g. Responsibility to participate in the CM process to the extent possible
h. Responsibility to cooperate with the CM plan

10. The CM offers to enroll the member in CM services and obtains consent and opensCM record and assigns the case for management.

11. Members electing not to enroll in the CM program provides contact information should the member choose to reconsider, notify the referral source and Primary Care Physician (PCP) of the members choice to opt out of CM services. Membersare informed and encouraged to take advantage of available health and wellness resources provided by health plans and community resources.

12. Assessment / identification of Service Needs – once the consent and assessment iscompleted, the CM completes the assessment
    a. The assessment is completed by a State licensed professional (RN or LCSW)and overseen by the RN UM Manager.

13. If the CM identifies a need for Behavioral Health Case Management during theassessment, s/he refers to the specific health plan guidance document for the process for referral for BH CM.
    a. S/he follow the process outlined and documents in the CM system.

14. The CM evaluates the information identifying member's service needs, opportunityfor intervention such as:
    a. Instrumental activities of daily living
    b. Cognitive functions
    c. Behavioral health status
    d. Lifestyle preferences and goals
    e. Lack of established treatment plan, or ineffective treatment plan
    f. Compromised patient safety
    g. Over- Under or inappropriate utilization of services
    h. Premature or delayed discharge from appropriate level of care
    i. Permanent or temporary alteration of functional status
    j. Member non-adherence to treatment or medications
    k. Medical/ psychosocial/functional complications
    l. Lack of education related to disease course or process
    m. Lack of family or social support
    n. Lack of financial resources to meet health needs
    o. Cultural and linguistic needs, preferences or limitations
    p. Caregiver resources
    q. Community resources and services
    r. Alternative financial and benefit resources

15. Members eligible for carve-out programs/ services / products are redirected to thedelegated entity or service provider for coordination of care.
16. Case Management Plan of Care - The CM works collaboratively with the member orauthorized representative to identify and consider member and authorized representative / caregiver needs and preferences to identify and document:
    a. Members of the multidisciplinary team
    b. Specific care needs
    c. Goal prioritization
    d. Intervention prioritization
    e. Caregivers and other sources of social support alternative benefits or financialresources
    f. Available community resources
    g. Appropriate level of care
    h. Appropriate healthcare services, equipment and supplies.
    i. Planning for continuity of care, including transition of care and transfers
        i. Includes both inpatient and outpatient services

17. The CM will collaborate with the member, authorized representative/ family to guidethe member toward health, wellness, adaptation, self-care and / or rehabilitation. The member will be encouraged to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

18. The CM works together with the PCP and/ or specialist to determine the significantmembers of the interdisciplinary team in the Plan of Care.

19. The CM provides leadership in developing and implementing the CM Plan of Careand relevant service needs identified included in the plan.

20. Individual Problem Identification - The CM collaborates with the member or authorized representative/ caregiver to identify specific individual problems during the assessment to identify a course of action for prioritizing long term and short-termgoals setting. Each problem has at least one goal and intervention. Problems drivegoal statements and facilitate the direction in which the member/caregiver participates in the Plan of Care. Each problem and its associated goal have interventions that are required to achieve the stated goals.

21. Goal Setting - The CM collaborates with the member or authorized representative and multidisciplinary team to establish measureable short-term and long-term goals,which promote evaluation of access, cost and quality of care. Once established, theCM and member / authorized representative prioritize the goals. Agreement is reached with the member and the multidisciplinary team prior to the implementation for the CM Plan of Care and the CM documents the review and approval in the electronic record.

22. Goals and objectives in the Plan of Care are supported by information in theassessment. Goals are:
    a. Member-driven

b. Realistic and clinically appropriate
c. Attainable and motivational for the member/ family/caregiver
d. Stated as measurable activities with timeframes forachievement
e. Identify the individual who is responsible for each activity
f. Identify criteria for completion
g. Set priorities of the goals
h. Short – term goals address acute and immediate clinical, psychosocial andfinancial needs
i. Long- term goals delineate activities to sustain health improvements oroptimal health status

23. The Plan of Care contains
    a. Interventions provided to, for, or with the member to achieve goals.
    b. Skills training interventions structured with time frames to achieve educationaland self-management goals.
    c. Schedule for follow-up and communication is based on the member's needsand clinical judgment of the CM.
    d. Discharge goals established to target optimal health.
    e. Development and communication of self-management action plan for themember.

24. The CM documents the plan of care via the electronic CM system. S/he utilizes theautomatic documentation of the staff member's ID and time action on the case or interaction with the member occurred and uses Microsoft Outlook to schedule followactions / scheduled contact with the members,

25. The member, authorized representative, attending physician, or specialist may request to review, receives or modifies the Plan of Care at any time. Care plans derived from Milliman Chronic Care Guidelines are sent only with the required language related to Milliman copyright requirements and modification of guidelines.

26. Implementation of the Plan of Care
    a. The CM implements the activities and interventions in the Plan of Care alongwith the member and the multidisciplinary team.

27. The CM ensures that:
    a. Services are consistent with the member's benefits and are provided byappropriate service providers.
    b. Referrals are made to available contracted service providers, vendors,wellness programs and community resources.
    c. If contracted providers are not available, non- contracted providers may beutilized through a Memo of Understanding (MOU) or Letter of Agreement (LOA).
    d. Interventions which support the coordination are documented in the electronicCM record.

28. The Plan of Care may be revised:
    a. Whenever there is a significant change in any items addressed in the plan.
    b. When a special review is requested by the member, PCP, CM ormultidisciplinary team member
    c. At the time of case reviews by manager, supervisor or Medical Director.

29. The CM documents all care plan activities and revisions in the electronic recordsystem.

30. Monitoring and Evaluation is achieved by the following:
    a. CM services are provided to support the needs and goals identified in thePlan of Care which respect the member's rights and choices.
    b. The CM continually monitors the quality of care, services and productsdelivered to the member to determine if the goals are being met.
    c. When developing the Plan of Care, the CM indicates the dates when the Planwill be formally evaluated based upon the goals.
    d. The CM assesses whether the goals continue to be appropriate and realistic,and what interventions may be implemented to achieve or enhance positive outcomes.
    e. The CM identifies any barriers to meeting the established goals or complyingwith the Plan of care and coordinates interventions to address any barriers.
    f. The CM contacts the member or authorized representative at establishedtime frames based on the member's needs.
    g. The CM may base the assessment of progress on information obtained fromthe member or authorized representative, guardian, family members, attending physician, professional and non-professional caregivers, and multidisciplinary team members.

31. The CM collaborates with the multidisciplinary team to make changes or modify theplan of care when:
    a. Changes are noted in the clinical, psychosocial or financialstatus for which revisions to the plan are recommended
    b. The member is not making progress towards goals andobjectives
    c. The member is not adhering to the agreed upon Plan of Care
    d. Quality of care, access or other issues with a provider is noted

32. The CM documents:
    a. The achievement of goals noting which goals were achieved through CMinterventions.
    b. Referral requirements, including evaluation of each provider's scope ofpractice, quality of care, access and ability to meet the member's needs
    c. Quantifiable impact, quality of care and/or life improvements measure againstthe CM goals.

33. The member remains active in CM for as long as necessary to implement the individual Plan of Care, which is designed to achieve empowerment of the memberin maintaining the optimal level of health, safety and wellness.

34. The CM Manager is responsible for ensuring case closures are based on sound rationale and follow discharge criteria as described. The CM will review each caseclosure with manager including the rationale for case closure and strategies for follow-up service plan once the case is closed.

35. Discharge - Member is discharged from the CM Program when any of the followingoccur:
    a. Achievement of targeted goals as described in the Plan of Care
    b. Member or family is unwilling to actively participate in the CM process or Planof Care
    c. Termination of eligibility
    d. Death

36. At the time of case closure the CM will:
    a. Discuss the discharge process with the member or authorized representativeand/ or family regarding the termination of services, including the rationale forcase closure
    b. Inform the multidisciplinary team regarding the case closure, including therationale for closure
    c. In collaboration with the member and/or family members and multidisciplinaryteam, develop a follow-up service plan for the member's discharge from CM
    d. Document ongoing self-care instructions in the Plan of Care
    e. Close the CM case file
    f. The CM will notify the following parties, by telephone or in writing when amember's case has been closed from CM.
        i. The member or authorized representative
        ii. The member's Primary Care Physician
        iii. The providers/specialists involved in the member's care
        iv. All members of the multidisciplinary team

Notifications will include how to reactivate CM services in the event there is achange in the member's condition which would necessitate CM services to resume.

37. Support Systems assist the CM in managing the cases:
    a. Clinical.
        i. Utilization of clinical guidelines or algorithms to guide case managersthrough the assessment and ongoing management of a member
        ii. Utilization of Medical Director's review and evaluation of the case
        iii. Utilization of Specialty Care Advisory physicians
    b. Information Systems:
        i. Electronic CM system
        ii. Automated software feature that records and date stamps each

actiontaken regarding the Member or interaction with the Member, MSO or Provider

iii. Automatic prompt and reminder of the next steps and follow-up contactscheduled with member

38. Case Record
    a. Elements of the CM:
        i. Patient Profile
        ii. Assessment 1 & 2
        iii. Disease Specific Assessments
        iv. Care Plan – Short & Long Term Goals
        v. Diagnosis History
        vi. Medication List
        vii. Case Summary
        viii. User Guide

Reference(s)

National Committee for Quality Assurance (NCQA) Standards, NCQA QI 5 El F 12 and 13

Case Management Society of America (CMSA): Standards of Practice for Case Management
Case Management Society of America : Case Management Caseload Concept Paper: Proceedings of the Caseload Work Group

Attachments:

None

IMPERIAL MANAGEMENT
ADMINISTRATIVE SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Continuation of Critical Business Processes for Security of Electronic Protected Health Information	
Policy Number(s): 10-042	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group shall follow the procedures set forth in this policy.

PURPOSE

To define the process for ensuring the Continuation of Critical Business Processes for Security of Electronic Protected Health Information.

POLICY

IHHMG ensures the Continuation of Critical Business Processes for Security of Electronic Protected Health Information.

PROCEDURE

1. If applications are not operational, staff will document the member's ID number when researching/responding to inquiries.

2. If shared drive is operational, documentation will be on a log that is electronically filed on a secure folder on the shared drive

3. If shared drive is not operational, documentation shall be handwritten on a log.

   3.1. The log is kept face down on the employee's desk

   3.2. The log is locked any time the employee leaves the desk

   3.3. The log is locked in the secure cabinet at the close of business

4. Once applications are operational, the contents of the log shall be transferred to the individual member's files.

    4.1. The electronic or hand written logs shall be shredded once the information is transferred to the member's record.

Reference(s)
§164.308(a)(7)(ii)(A)

Attachments:
Member Activity / Inquiry Log During a Disaster

Member Activity - Inquiry Log During A D

IMPERIAL MANAGEMENT
ADMINISTRATIVE SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Transition Management (30 days Post Inpatient Stay)	
Policy Number(s): 10-043	**Orig. Date:** 09/14/16
Effective Date: 09/14/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group shall follow the procedures set forth in this policy.

PURPOSE

IHHMG shall ensure adequate post-discharge follow-up of its members

POLICY

It is the policy of IHHMG that member contact is initiated within 30-days of discharge from the acute/skilled setting

PROCEDURE

The following processes shall be completed when performing transition management post in-patient stay:

1. Medication reconciliation
2. Timely physician follow-up appointments evaluated and scheduled as needed.
3. Home care needs addressed appropriately (ADLs, IADS, Transportation, DME, Home Health Services, etc.)
4. Coordinate care, connecting to community resources/services.
5. Promote self-management (education, empowerment).
6. Evaluate for long term needs and transfers to CCM/DM as needed.

Reference(s)
2015 NCQA QI 6

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATORY SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: End of Life Services (EOL)	
Policy Number(s): 10-044	**Orig. Date:** 12/18
Effective Date: 12/18	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ **IHP** ☒ **IHHMG** ☒ **IICT**	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP, and Specialist shall followthe procedures set forth in this policy.

PURPOSE

The purpose of this policy is to provide Medi-Cal managed care members/providers with guidance onthe End of Life (EOL) Option Act.

POLICY

Assembly Bill (AB) x2-15 (Eggman, Chapter 1, Statues of 2015)1 added Part 1.85 (commencing withSection 443) to Division 1 of the Health and Safety Code to create the "End of Life Option Act" (Act). The Act establishes a benefit to permit terminally ill beneficiaries, age 18 or older with the capacity tomake medical decisions, to be prescribed aid-in-dying medications if certain conditions are met.

Provision of these services by health care providers is voluntary, and refusal to provide these services will not place any physician at risk for civil, criminal, or professional penalties. Effective June 9, 2016, Medi-Cal Fee-For-Service (FFS) will provide coverage and reimbursement for physicians who decide toprovide EOL services.

PROCEDURE

EOL services, as defined by the Act, include consultations and the prescription of an aid-in-dying drug.EOL services are a "carve-out" for Medi-Cal managed care and are covered by Medi-Cal FFS. Beneficiaries are responsible for finding a Medi-Cal FFS physician for all aspects of the EOL benefit.

During an unrelated visit with a physician, a beneficiary may provide an oral request for EOL services. Ifthe physician is also enrolled with the Department of Health Care Services (DHCS) as a Medi-Cal FFS provider, that physician may elect to become the beneficiary's attending physician as he or she proceeds through the steps in obtaining EOL services. EOL services following the initial visit are no longer the responsibility of Imperial Health Holdings Medial Group, and must be completed by a Medi- Cal FFS attending physician, or a Medi-Cal FFS consulting physician. Alternatively, if the MCP physician is not a Medi-Cal FFS provider, the physician may document the oral request in his or her medical records as part of the visit; however, the MCP physician should advise the beneficiary that following the initial visit he or she must select a Medi-Cal FFS physician in order for all of the remainingAct requirements to be satisfied.

Additional information regarding the roles and responsibilities of the Medi-Cal FFS physician can be found in AB x2-15 (Eggman, Chapter 1, Statutes of 2015) as well as in a forthcoming Medi-Cal ProviderManual.

Imperial Health Holdings Medical Group is responsible for ensuring that their delegates comply with allapplicable state and federal law and regulations and other contract requirements.

Reference(s)

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL 16-006.pdf

Attachments:

APL16-006 EOL Services.pdf

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Utilization Management Department
Policy and Procedure

Policy Title: 10-045 Initial Health Assessment (IHA)- IHEBA, Immunization, Smoking Cessation. Alcohol Misuse Screening/Behavioral counseling Interventions	
Policy Number(s): 10-045	**Orig. Date:** 05/01/16
Effective Date: 10/05/22	**Revision(s) Date:** 09/01/19, 05/21/21, 7/14/21, 08/17/22, 10/05/22
MSC Committee Approval: **Date:** David MKA Liu **11/10/22**	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date: 11/10/22**
Applicable to: ☒ **IHP** ☒ **IHHMG** ☒ **IICT** ☒ **HCMG** ☒ **LSMG**	**SCOPE: UM**

SCOPE
Imperial Health Plan, Imperial Insurance Companies, Imperial Health Holdings Medical Group, HealthCosmos Medical Group, and LoneStar Medical Group shall follow the procedures set forth in this policy.

PURPOSE
To ensure and promote timely access to an initial health assessment (IHA) consisting of a comprehensive health history, physical examination, and the Staying Healthy Assessment or a comparable and approved health education behavioral assessment (IHEBA) including Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT). The IHA will allow the primary care provider to comprehensively assess the member's current, acute, chronic and preventive health needs. The visit should include immunizations, counseling, including Tobacco Cessation, medical testing and treatment, and review of Preventive Services.

POLICY
Imperial Health Holdings Medical Group is required by the California Department of Health Care Services (DHCS), the Centers for Medicare and Medicaid (CMS) to ensure that new enrollees receive an Initial Health Assessment (IHA) within 90 days of the effective date of enrollment. A minimum of three documented attempts must be made to schedule the timely IHA, with at least one phone call and one letter. If the member has been scheduled for IHA but missed the schedule IHA appointment, three additional attempts must be documented to reschedule the appointment, at least one attempt to contact the member by telephone and at least one attempt to contact the member by letter. Also, a good faith effort to annually notify enrollees about the Annual Wellness Visit to include a review of current opioid prescriptions, screening for potential substance use disorders, and a referral for treatment as appropriate.

Assessment Components

A. An IHA consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA). An IHEBA enables primary care providers to

comprehensively assess the member's current acute, chronic, and preventive health needs, as well as identify those members whose health needs require coordination with appropriate community resources and other agencies for carve-out services.

B. Staying Healthy Assessment (SHA)/Individual Health Education Behavioral Assessment (IHEBA) requirements for Low-Income Health Program enrollees. Since 2011, the State of California has been taking steps towards expanding Medicaid under the Affordable Care Act by implementing Low Income Health Programs (LIHPs) in most California counties. Effective January 1, 2014, LIHP beneficiaries were transitioned to Medi-Cal managed care, or into subsidized health coverage through California's health benefit exchange, Covered California, as authorized by the Affordable Care Act. In accordance with regulatory requirements, LIHP beneficiaries must receive a comprehensive Initial Health Assessment (IHA) within the first 90 days of enrollment with the plan. An IHA consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA). An IHEBA enables primary care providers to comprehensively assess the member's current acute, chronic, and preventive health needs, as well as identify those members whose health needs require coordination with appropriate community resources and other agencies for carve-out services.

PROCEDURE

A. The assigned PCP must provide an Initial Health Assessment and Individual Health Education Behavioral Assessment for each new member within 90 days of the effective date of enrollment.

B. Information is sent to all new members to notify them of their required IHA appointment. The PCP must make at least two (2) attempts to contact a member and schedule an IHA. Initial outreach may include, but is not limited to:
    1. New member enrollment package/materials
    2. IHA reminder messages
    3. Member newsletters
    4. Member website
    5. Phone calls

C. The initial history and physician exam include:
    1. Blood pressure.
    2. Height and weight.
    3. Total serum cholesterol measurement for men ages 35 and over and women ages 45 and over.
    4. Clinical breast examination for women over 40.
    5. Mammogram for women age 50 and over.
    6. Pap smear (or arrangements made for performance) on all women determined to be sexually active.
    7. Chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for Chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
    8. Screening for TB risk factors, including a Mantoux skin test on all persons determined to be at high risk.
    9. Health education behavioral risk assessment.

D. The PCP must ensure that all adults receive all necessary immunizations at the time

of any health care visit. PCP must ensure the timely provision of vaccines in accordance with the most current Adult Immunization recommendation published by the Advisory Committee on Immunization Practices (ACIP). Immunizations do not require prior authorization.

a. PCPs will document the following in each members' medical record:

1. Attempts to provide immunizations. If member refuses the immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the member or guardian of the member.
2. If the responsible party refuses to sign this statement, the refusal shall be noted in the member's medical record.

E. The PCP must make arrangements for any needed follow-up services with the member that reflect the findings or risk factors discovered during the IHA and health education behavioral assessment. The PCP must document the member's completed IHA and health education behavioral assessment tool in the member's medical record and is referenced during subsequent preventive health visits.

F. The PCP must document all outreach/actions/outcomes in the medical record, including, but not limited to:

1. Missed appointments
2. Attempts to follow-up
3. Monitoring and intervention process to ensure appropriate utilization of IHA/IHEBA standards.

G. All attempts shall be documented in the member's medical record. PCP documented attempts that demonstrate unsuccessful efforts to contact a member and schedule an IHA shall be considered evidence in meeting this requirement.

i. Requirements for Missed or broken appointments are as follows

1. First Attempt – Phone call to member (or written letter if no telephone). If member does not respond, then;
2. Second Attempt – Phone call to member (or written letter if no telephone). If member does not respond then;
3. Third Attempt – Written letter.

H. If the PCP has access to a new Medi-Cal member's medical records from a previous Plan or other PCP, and those records indicate that the member has had an IHA within the previous 12 months, and the examination provides evidence that there is no urgency for an IHA, then the visit can be waived until the next periodic visit is due.

I. 1. For members whose health status does not indicate urgency, and if conducting the assessment as part of the first visit is not feasible, the PCP must contact the member within 90 days after the member's first medical visit to schedule an initial health assessment appointment. Process to identify Members who needs an IHA:

1. Data Manager will pull monthly report to identify new enrollees and members without IHA encounters.
2. Data Manager will provide report to UM Team
3. A list will be populated with members without IHA
4. Letter will be sent to PCP, requesting to complete IHA with member.

J. Using the Staying Healthy Assessment

1. The Staying Healthy Assessment is an age-appropriate questionnaire designed to be self-administered by the patient or parent. Alternatively, the

patient or parent may be asked SHA questions verbally and responses recorded directly in the patient's electronic medical record. Current members who have not completed an updated SHA must complete it during their next preventive care.

The SHA Periodicity Table and SHA administration policy is summarized in the below table:

Questionnaire	Administer	Administer/Re-administer		Review
Age Groups	Within 120 Days of Enrollment	1st Scheduled Exam *(after entering new age group)*	Every 3-5 Years	Annually *(Interval Years)*
0-6 mo.	√			
7-12 mo.	√	√		
1-2 yrs.	√	√		√
3-4 yrs.	√	√		√
5-8 yrs.	√	√		√
9-11 yrs.	√	√		√
12-17 yrs.	√	√		√
Adult	√		√	√
Senior	√		√	√

The Staying Healthy Assessment comes in different languages and can be accessed through: https://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx for more detailed information on the assessment.

K. IHHMG will cover all FDA-approved tobacco cessation medications for adults who use tobacco products. This includes over-the -counter medications with a prescription from the provider.

At least one FDA-approved tobacco cessation medication must be available without prior authorization.

1. The PCP shall review the SHA's questions on tobacco with the member.
2. IHHMG shall offer telephone counseling at no cost to members who wish to quit smoking whether or not those members opt to use tobacco cessation medications
3. IHHMG will provide minimum of at least four counseling sessions of at least ten minutes (individual/group/telephone per member's choice)
4. IHHMG will cover tobacco cessation counseling for at least two separate quit attempts per year, without prior authorization and no mandatory breaks between quit attempts.
5. The PCP will refer members who use tobacco to the California Smokers' Helpline (1-800-NO-BUTTS)
6. The PCP will ask all pregnant women if they use tobacco or are exposed to tobacco smoke. Offer at least one face-to-face tobacco cessation counseling session per quit attempt. Referral to a tobacco cessation quit line, such as the Helpline.
7. Counseling services must be covered for 60 days after delivery, plus any additional days needed to end the respective month.
8. IHHMG shall use the USPHS Clinical Practice Guideline treating Tobacco Use and Dependence 2008 Update for provider training on tobacco cessation treatments.
9. IHHMG shall ensure their primary care practices institute a tobacco user identification system, including the use of International classification of Diseases (ICD10 codes). The full set of ICD-10 codes to record tobacco use can be found at www.ctri.wisc.edu/documents/icd10.pdf.

Organizations are required to provide all preventive services consistent with the United States Preventive Services Task Force (USPSTF) recommendations. The USPSTF recommends that clinicians screen, at least yearly, adults ages 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse. Youth aged 18-21 are eligible for additional screening benefits under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

The PCP will follow requirements related to Alcohol Misuse Screening/Behavioral counseling Interventions for Alcohol Misuse.

L. When a member answers "yes" to the IHEBA alcohol pre-screen question, the PO must ensure that the PCP offers the member an expanded, validated alcohol screening questionnaire. Organization and PCP requires the use one of the following validated tools when screening for alcohol misuse:

- Alcohol Use Disorder Identification Test (AUDIT) or
- Alcohol Use Disorder Identification Test—Consumption (AUDIT-C).
- A single-question screening, such as asking, "How many times in the past year have you had 4 (for women and all adults older than 65 years) or 5 (for men) or more drinks in a day?
- Organization informs contracted practitioners of requirement to provide screening & Behavioral Counseling Interventions.
- Organization provides contracted practitioners with access to the screening tools
- Members who, upon screening and evaluation, meet the criteria for an Alcohol Use Disorder (AUD) as defined by the current DSM (DSM-5, or as amended), or whose diagnosis is uncertain, are referred for further evaluation and treatment to the county department for alcohol and substance use disorder treatment services, or a DHCS-certified treatment program.
- Organization ensures that providers in primary care settings offer and document alcohol misuse screening services.

M. The PCP offers members with brief behavioral counseling interventions, to reduce alcohol misuse when, during the screening process, a member is identified as being engaged in risky or hazardous drinking. Behavioral counseling intervention(s) for alcohol misuse vary in their specific components, administration, length and number of interactions, but may include cognitive behavioral strategies, such as action plans, drinking diaries, stress management, or problem solving. Interventions may be delivered by face-to-face sessions, written self-help materials, computer- or Web-based programs, or telephone counseling.

N. IHHMG must offer at least one, but may offer up to a maximum of three, behavioral counseling interventions for alcohol misuse per year. Additional behavioral counseling interventions must be authorized when medically necessary; however, medical necessity must be documented by the member's PCP.

1. PCPs maintain documentation of the alcohol misuse screening of their members. When a member transfers from one PCP to another, the receiving PCP must obtain the member's prior medical records, including those pertaining to the provision of preventive services office visit (e.g. well-baby, well-child, well-woman exam), according to the SHA periodicity table below.

O. Systems are employed to identify and address barriers to enrollee compliance with prescribed treatments or regimens.

P. There is appropriate, timely, and confidential exchange of clinical information among provider network components.

Q. If the member refuses to participate and/or provide information, this should be documented in the medical record.

R. Annual Wellness visit must include:

- a review of the beneficiary's current opioid prescription
- screening for potential substance use disorders, including a referral for treatment as appropriate

S. All regular health visits include, but are not limited to the following appointment types:

1. Initial Health Assessment (IHAs)
2. Pre-travel visits
3. Well patient checkups

Reference(s)

MMCD Policy Letter No. 08-003, CA Code of Regulations, Title 22, Sections 53851(b)(1), 53902(m), and 53910.5(a)(1)
Special Needs Plan

Attachment(s)

CDC 2019 Recommended Imm

CDC 2019 Recommended Imm

IMPERIAL MANAGEMENT
ADMINISTRATIVE SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Asthma Treatment Care AB2185	
Policy Number(s): 10-001	**Orig. Date:** 01/01/18
Effective Date: 01/01/18	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group shall follow the procedures set forth in this policy. Asthma treatment and management is required by California Health and Safety Code 1367.06.

PURPOSE

To comply with code regulation and ensure members are receiving the care they need.

POLICY

To comply with code regulation and ensure members are receiving the care they need.

PROCEDURE

IHHMG covers all medically necessary care, equipment, and supplies for the treatment and management of asthma. IHHMG coverage includes, but is not limited to, the following asthma equipment and supplies when medically necessary for the management and treatment of pediatric asthma[4]and adult asthma:

A. Inhaler spacers when medically necessary for the management and treatment ofasthma.
B. Nebulizers, including face masks and tubing
C. Peak flow meters

Quantities of equipment and supplies may be limited if the limitations do not inhibit appropriate compliance with treatment as prescribed by the member's treating practitioner.

Reference(s)
AB-2185 Asthma Treatment Care

Attachments:
AB-2185 Asthma Treatment Care

Bill Text - AB-2185
Asthma treatment ca

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Cancer Clinical Trials	
Policy Number(s): 10-002	**Orig. Date:** 01/01/18
Effective Date: 01/01/18	**Revision(s) Date:** 09/01/19
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ **IHP** ☒ **IHHMG** ☒ **IICT**	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group shall follow the procedures set forth in this policy. Formembers diagnosed with cancer accepted into phase I, phase II, phase III and/or phase IV clinical trials.

PURPOSE

To comply with code regulation and ensure members are receiving the care they need.

POLICY

To comply with code regulation and ensure members are receiving the care they need.

PROCEDURE

1) IHHMG covers all medically necessary care and supplies for the treatment for members diagnosed with cancer accepted into phase I, phase II, phase III and orphase IV clinical trials.

2) The treatment shall be provided in a clinical trial that either involves a drug that isexempt under federal regulations from a new drug application or is approved by one of the following:

   a) One of the National Institutes of Health.
   b) The federal Food and Drug Administration, in the form of an investigationalnew drug application.
   c) The United States Department of Defense.

d) The United States Veterans' Administration.

3) In the case of health care services provided by a participating and non- participating provider, the payment rate shall be at the agreed-upon rate.

4) Unless delegated to IHHMG, the health plan is responsible for determiningwhether treatment is considered investigational or experimental.

5) An immediate referral of all requests for experimental or investigational treatments, including clinical trials, will be sent to the health plan for initialdetermination, regardless of benefit exclusion.

6) Turnaround time:

   a) Standard requests within 24 hours of receipt of request
   b) Expedited requests must be completed and faxed on the same day ofmember or physician request.

7) If the request is related to transplants, the information must be sent directly to thehealth plan Case Management Transplant Department.

8) No denial of services considered experimental or investigational will be issued bythe Provider Organization.

9) An informational letter to member and practitioner will be issued immediatelywhen sending the experimental/investigational referral to the health plan.

Reference(s)
SB 37

Attachments:
SB 37 clinical cancer trials

SB 37 Senate Bill - CHAPTERED.pdf

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Knox-Keene AB 1324	
Policy Number(s): 10-003	**Orig. Date:** 01/01/18
Effective Date: 01/01/18	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group shall follow the procedures set forth in this policy. Regarding Knox-Keene AB 1324.

PURPOSE

To comply with code regulation and ensure members are receiving the care they need.

POLICY

To comply with code regulation and ensure members are receiving the care they need.

PROCEDURE

IHHMG may authorize a specific type of treatment by a provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization for any reason, including, but not limited to, the groupssubsequent rescission, cancellation, or modification of the member's or subscriber's contract or the plan's subsequent determination that it did not make an accurate determination of the member's or subscriber's eligibility. This section shall not be construed to expand or alter the benefits available to the member or subscriber under aplan. The Legislature finds and declares that by adopting the amendments made to thissection by Assembly Bill 1324 of the 2007–08 Regular Session it does not intend to instruct a court as to whether or not the amendments are existing law.

Reference(s)

Attachments:

Bill Text - AB-1324
Health care coverag

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: 120 Day Initial Health Assessment (IHA)- Linked Services	
Policy Number(s): 10-004	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:** 09/01/19
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP, and Specialist shall follow the procedures set forth in this policy.

PURPOSE

An IHA is a comprehensive assessment that is completed during a patient's initial encounter(s) with his/her PCP. Imperial Health Holdings Medical Group is required by the California Department of Health Care Services (DHCS), Managed Risk Medical Insurance Board (MRMIB), the Centers for Medicare and Medicaid and funders of Healthy Kids to ensurethat new members receive an Initial Health Assessment (IHA) within 120 days of enrollment and members less than 18 months old receive IHA within 60 days with the Health Plan.

POLICY

Assessment Components

A. An IHA consists of a history and physical examination and an Individual Health EducationBehavioral Assessment (IHEBA). An IHEBA enables primary care providers to comprehensively assess the member's current acute, chronic, and preventive health needs, as well as identify those members whose health needs require coordination with appropriate community resources and other agencies for carve-out services.

B. Staying Healthy Assessment (SHA)/Individual Health Education Behavioral Assessment(IHEBA) requirements for Low-Income Health Program enrollees. Since 2011, the State of California has been taking steps towards expanding Medicaid under the Affordable Care Act by implementing Low Income Health Programs (LIHPs) in most

California counties. Effective January 1, 2014, LIHP beneficiaries were transitioned to Medi-Cal managed care, or into subsidized health coverage through California's health benefit

exchange, Covered California, as authorized by the Affordable Care Act. In accordance with regulatory requirements, LIHP beneficiaries must receive a comprehensive Initial Health Assessment (IHA) within the first 120 days of enrollment with the plan. An IHA consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA). An IHEBA enables primary care providers to comprehensively assess the member's current acute, chronic, and preventive health needs, as well as identify those members whose health needs require coordination with appropriate community resources and other agencies for carve-out services.

PROCEDURE

A. The assigned PCP must provide an Initial Health Assessment/Individual Health Education Behavioral Assessment for each new Medi-Cal members within 120 daysand 60 days for children 18months or younger.
B. The initial history and physician exam include:
    a. Blood pressure.
    b. Height and weight.
    c. Total serum cholesterol measurement for men ages 35 and over and womenages 45 and over.
    d. Clinical breast examination for women over 40.
    e. Mammogram for women age 50 and over.
    f. Pap smear (or arrangements made for performance) on all women determined tobe sexually active.
    g. Chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for Chlamydia infection using the most current CDCguidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
    h. Screening for TB risk factors, including a Mantoux skin test on all personsdetermined to be at high risk.
    i. Health education behavioral risk assessment.

C. The PCP can use the Staying Healthy Assessment tool provided by DHCS to performthis assessment. The Staying Healthy Assessment comes in different languages and can be accessed through: https://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx for more detailed information on the assessment.

D. The PCP can use the Health Education Behavioral Assessment for children. The PCP must perform an assessment using the California Child Health and Disability Prevention(CHDP) program's age appropriate assessment. This is due for each child at the time ofenrollment during their IHA visit and can be accessed by the PCP through: **http://www.dhcs.ca.gov/services/chdp/Pages/Pub156.aspx** for CHDP health assessment guidelines.

E. The PCP must ensure that all children receive necessary immunizations at the time of any health care visit. PCP must ensure the timely provision of vaccines in

accordance with the most recent childhood immunization schedule and recommendations publishedby the Advisory Committee on Immunization Practices (ACIP) and can be accessed by the PCP through: **http://www2a.cdc.gov/nip/kidstuff/newscheduler_le/** for childhoodimmunization schedule.

F. The PCP must make arrangements for any needed follow-up services with the memberthat reflect the findings or risk factors discovered during the IHA and health education behavioral assessment.

G. The PCP must document the member's completed IHA and health education behavioralassessment tool in the member's medical record and is referenced during subsequent preventive health visits.

H. The PCP must document all outreach/actions/outcomes in the medical record,including, but not limited to:

   a. Missed appointments
   b. Attempts to follow-up
   c. Monitoring and intervention process to ensure appropriate utilization ofIHA/IHEBA standards.

I. Information is sent to all new Medi-Cal members to notify them of their required IHA appointment. The PCP must make at least two (2) attempts to contact a member andschedule an IHA. Initial outreach may include, but is not limited to:
   a. New member enrollment package/materials
   b. IHA reminder messages
   c. Member newsletters
   d. Member website
   e. Phone calls

J. All attempts shall be documented in the member's medical record. PCP documented attempts that demonstrate unsuccessful efforts to contact a member and schedule anIHA shall be considered evidence in meeting this requirement.
      i. Requirements for Missed or broken appointments are as follows
         1. First Attempt – Phone call to member (or written letter if notelephone). If member does not respond, then;
         2. Second Attempt – Phone call to member (or written letter if notelephone). If member does not respond then;
         3. Third Attempt – Written letter.

K. If the PCP has access to a new Medi-Cal member's medical records from a previous Plan or other PCP, and those records indicate that the member has had an IHA withinthe previous 12 months, and the examination provides evidence that there is no urgency for an IHA, then the visit can be waived until the next periodic visit is due.
   a. For members whose health status does not indicate urgency, and if conducting the assessment as part of the first visit is not feasible, the PCP must contact the member within 90 days after the member's first medical visit to schedule

an initialhealth assessment appointment.

L. USING THE STAYING HEALTHY ASSESSMENT

a. The Staying Healthy Assessment is an age-appropriate questionnaire designed to be self-administered by the patient or parent. Alternatively, the patient or parent may be asked SHA questions verbally and responses recorded directly inthe patient's electronic medical record. Current members who have not completed an updated SHA must complete it during their next preventive care

office visit (e.g. well-baby, well-child, well-woman exam), according to the SHAperiodicity table below.

The SHA Periodicity Table and SHA administration policy is summarized in the below table:

Periodicity	Initial SHA Administratio	Subsequent SHA Administration / Re-Administration		SHA Review
Age Groups	Within 120 Days of Enrollmen	1st Scheduled Exam (after entering	Every 3-5 years	Annually (Intervening years between
0-6 mo.	☐			
7-12 mo.	☐	☐		
1-2 yrs.	☐	☐		☐
3-4 yrs.	☐	☐		☐
5-8 yrs.	☐	☐		☐
9-11 yrs.	☐	☐		☐
12-17 yrs.	☐	☐		☐

M. If the member refuses to participate and/or provide information, this should be documented in the medical record.

Reference(s)

Medi-Cal Business line

Attachments:

CDC 2019 Recommended Imm

CDC 2019 Recommended Imm

IMPERIAL MANAGEMENT
ADMINISTRATIVE SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Staying Healthy Assessment (SHA)	
Policy Number(s): 10-005	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:** 07/07/21
MSC Committee Approval: **Date:** 07/29/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 07/29/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

All Utilization Management staff and Imperial Health Holdings Medical Group Primary Care Providers shall follow the procedures set forth in this policy.

PURPOSE

The SHA is the Individual Health Education Behavioral Assessment (IHEBA) developed by the Department of Health Care Services (DHCS). The IHEBA is a required component of the Initial Comprehensive Health Assessment (IHA)

POLICY

The Imperial Health Holdings Medical Group Primary care providers (PCPs) are responsible for reviewing each member's SHA in combination with the following relevant information:

- Medical history, conditions, problems, medical/testing results, and member concerns.
- Social history, including member's demographic data, personal circumstances, family composition, member resources, and social support.
- Local demographic and epidemiologic factors that influence risk status.

To reduce the prevalence of chronic disease for MCP members and decrease costs over time, MCP providers should use the SHA to identify health-risk behaviors and evidence-based clinical prevention interventions that should be implemented. MCPs should use interventions that combine patient education with behaviorally oriented counseling to assist members with acquiring the skills, motivation, and support needed to make healthy behavioral changes.

PROCEDURE

MCPs must ensure that each member completes a SHA in accordance with the following guidelines and timeframes prescribed below

1. New Members

    1.1. New members must complete the SHA within 120 days of the effective date of enrollment as part of the IHA. The effective date of enrollment is the first day of the month following notification by the Medi-Cal Eligibility Data System (MEDS) that a member is eligible to receive services.

2. Current Members

    2.1. Current members who have not completed an updated SHA must complete it during the next preventive care office visit (e.g. well-baby, well-child, well-woman exam), according to the SHA periodicity table.

3. Pediatric Members

    3.1. Members 0–17 years of age must complete the SHA during the first scheduled preventive care office visit upon reaching a new SHA age group. PCPs must review the SHA annually with the patient (parent/guardian or adolescent) in the intervening years before the patient reaches the next age group.

    3.2. Adolescents (12–17 years) should complete the SHA without parental/guardian assistance beginning at 12 years of age, or at the earliest age possible to increase the likelihood of obtaining accurate responses to sensitive questions. The PCP will determine the most appropriate age, based on discussion with the parent/guardian and the family's ethnic/cultural background.

4. Adult and Senior Members

    4.1. There are no designated age ranges for the adult and senior assessments, although the adult assessment is intended for use by 18- to 55-year-olds. The age at which the PCP should begin administering the senior assessment to a member should be based on the patient's health and medical status, and not exclusively on the patient's age.

The adult or senior assessment must be re-administered every 3 to 5 years, at a minimum. The PCP must review previously completed SHA questionnaires with the patient every year, except years when the assessment is re-administered.

Although not required, annual administration of the SHA is highly recommended for the adolescent and senior groups because behavioral risk factors change frequently during these years

SHA Completion by Member:

1. Members should be provided with the following information and guidance on completing the SHA questionnaire:

   1.1. The PCP will use the information to identify behavior risks and to assist the member in adopting healthy behaviors.

   1.2. SHA translations, interpretation services, and accommodations for any disability are available, if needed. The PCP or clinic staff, as appropriate, can also assist the member in completing the SHA.

2. The completed SHA will be kept in the member's confidential medical record.

   2.1. Each member has the right to not answer any assessment question and to refuse, decline, or skip the entire assessment.

   2.2. Each member should be encouraged, when appropriate, to complete the SHA without assistance because this may increase the likelihood of obtaining accurate responses to sensitive or embarrassing questions.

   2.3. If preferred by the member or PCP, the PCP or clinic staff, as appropriate, may orally ask the assessment questions and record responses on the questionnaire or directly into an electronic health record or other electronic format.

3. PCP's Responsibility to Provide Counseling, Assistance, and Follow-Up:

   3.1. The PCP must review the completed SHA with the member and initiate a discussion with the member regarding behavioral risks the member identified in the assessment. Clinic staff members, as appropriate, may assist a PCP in providing counseling and following up if the PCP supervises the clinical staff members and directly addresses medical issues.

   3.2. The PCP must prioritize each member's health education needs and initiate discussion and counseling regarding high-risk behaviors.

   3.3. Based on the member's behavioral risks and willingness to make lifestyle changes, the PCP should provide tailored health education counseling, intervention, referral, and follow-up. Whenever possible, the PCP and the member should develop a mutually agreed-upon risk reduction plan.

   3.4. The PCP must review the SHA with the member during the years between re-administration of a new SHA assessment. The review should include discussion, appropriate patient counseling, and regular follow-up regarding risk reduction plans.

4. SHA Documentation by PCP:

4.1. The PCP must sign, print his/her name, and date the "Clinic Use Only" section of a newly administered SHA to verify that it was reviewed and discussed with the member.

4.2. The PCP must document specific behavioral-risk topics and patient counseling, referral, anticipatory guidance, and follow-up provided, by checking the appropriate boxes in the "Clinical Use Only" section.

4.3. The PCP must sign, print his/her name, and date the "SHA Annual Review" section of the questionnaire to document that an annual review was completed and discussed with the member.

4.3.1. A member's refusal to complete the SHA must be documented on the age-appropriate

4.3.1.1. SHA questionnaire by:

4.3.1.1.1. Entering the member's name (or person completing the form), date of birth, and date of refusal in the header section of the questionnaire.

4.3.1.1.2. Checking the box "SHA Declined by Patient."

4.3.1.1.3. Having the PCP sign, print his or her name, and date the "Clinic Use Only" section of the SHA.

4.3.1.1.4. Keeping the SHA refusal in the member's medical record.

4.4. The PCP may make notations in the "Clinic Use Only" column to the right of the questions, but this is not required.

5. Provider Training:

5.1. MCPs and Imperial Health Holding Medical Group must provide training on IHEBA contract requirements to all contracted PCPs and subcontractors. At a minimum, provider training must include:

5.1.1. IHEBA contract requirements.

5.1.2. Instructions on how to use the SHA or DHCS approved alternative assessment.

5.1.3. Documentation requirements.

5.1.4. Timelines for administration, review, and re-administration.

5.1.5. Specific information and resources for providing culturally and linguistically appropriate patient health education services/interventions.

5.1.6. MCPs and Imperial Health Holdings Medical Group-specific information regarding SHA resources and referral.

MCPs and Imperial Health Holdings Medical Group shall provide resources and training to its providers and subcontractors to ensure the delivery of culturally and linguistically appropriate patient health education services and to ensure that the special needs of vulnerable populations, including SPDs and persons with limited English skills, are addressed in the delivery of patient services.

Electronic or Other Formats:

1. Providers may implement the SHA in an electronic format without prior approval from MMCD, as long as they notify their contracted MCP at least two months before they begin using the electronic format. Providers may manually add the SHA questions into an electronic medical record, scan the SHA to use it as an electronic medical record, or use the SHA in another alternative electronic or paper-based format. When Providers use an alternative format, they must include:

   1.1. All updated SHA questions and not alter them and
   1.2. A way for the provider to document his/her signature.

2. Alternative IHEBA:

   2.1. Imperial Health Holdings Medical Group shall continue to strongly promote the use of the SHA to its PCPs in its provider network and will continue to utilize the Health Plans' SHA form in their prescribed format.

IHHMG shall ensure that PCPs have the means to obtain an adequate supply of the SHA questionnaires or DHCS-approved alternative assessment forms and must make sure DHCS approved alternative assessment forms are available in the threshold languages of their members or have interpreters available to translate the questionnaires into a needed language.

Reference(s)
DHCS POLICY LETTER 13-001 (REVISED)- REQUIREMENTS FOR THE STAYING HEALTHY ASSESSMENT/INDIVIDUAL HEALTH EDUCATION BEHAVIORAL ASSESSMENT

http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2013/PL13-001.pdf

SHA questionnaires and resources will be available on the DHCS website at:
http://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Comprehensive PerinatalServices Program CPSP	
Policy Number(s): 10-006	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group shall follow the procedures set forth in this policy.

PURPOSE

To ensure the provision of timely access to perinatal services from a perinatal provider without prior authorization.

POLICY

It is the policy of Imperial Health Holdings, Medical Group that all pregnant members shall have access to care in accordance with the Comprehensive Perinatal Services Program (CPSP), which integrates health education, nutrition, and psychosocial services with obstetricalcare.

PROCEDURE

Member Rights:

1. The Member's participation in CPSP is voluntary and is offered to all regardless of payersource (i.e. Medicare, Medi-Cal, Health Families, Commercial, or no evidence of insurance).

1.1. If the member declines services the provider shall document such in a retrievableformat (in medical record, EMR, CPSP log

2. Obstetrical care providers inform the member of the availability of CPSP services and

howto access them.

3. The members are informed of their rights and responsibilities.

4. Prenatal care is a **sensitive service**.

4.1. Adolescents may access sensitive services without prenatal consent.

4.2. Basic prenatal care does not require referral or prior authorization for anypatient/participant/client.

Pregnancy Care

1. The initial prenatal visit must be available within seven (7) days of the initial referral orrequest for pregnancy-related services.

2. Obstetric providers are required to provide care for the member using standards consistentwith the American College of Obstetricians and Gynecologists (ACOG) guidelines recommendations.

3. ACOG recommends the following examination schedule for a woman with anuncomplicated pregnancy:

3.1. Every 4 weeks for the first 28 weeks' gestation

3.2. Every 2-3 weeks until 36 weeks' gestation

3.3. Weekly until delivery

3.4. Postpartum, 4-8 weeks after delivery

4. Medical/obstetrical, nutrition, psychosocial, and health education risk assessments are completed on all pregnancy women within 4 weeks of the initiation of pregnancy-relatedservices, and at each subsequent trimester and postpartum.

4.1. All identified risk conditions are followed up by interventions designed to ameliorate orremedy the condition or problem in a prioritized manner.

5. Women with medical/obstetrical, nutrition, psychosocial and/or health education risks mayrequire closer surveillance.

6. The obstetric provider according to the nature and severity of the risk and/or identifiedproblems determines the appropriate interval between visits.

7. Recommended intervals for routine tests and as-indicated test for individual membersduring pregnancy is as follows:

7.1. Initial visit (as early as possible)

7.2. Hemoglobin or hematocrit measurement

7.2.1. Urinalysis, including microscopic examination and infection screen

7.3. Blood group and Rh type determinations

7.4. Antibody screen

7.5. Rubella antibody titer measurement

7.6. Syphilis screen (VDRL/RPR)

7.7. Cervical Cytology

7.8. HIV education, counseling and voluntary testing

7.9. Tuberculosis testing

7.10. Chlamydia testing

7.11. Gonorrhea culture

7.12. Blood pressure

7.13. Complete medical/obstetrical history including genetic risk assessment andreview of systems

7.14. Complete physical examination

7.15. Orientation to CPSP

7.16. Prescription and/or dispensing 300-day supply of vitamin/mineral supplements asindicated

8. Counseling related to:

8.1. Danger signs/what to do in an emergency

8.2. Seat belt safety

8.3. Tertogen

8.4. Smoking, alcohol, and other substance use

9. Referral to Woman, Infant, and Children program (WIC)

9.1. The PCP and/or Women's Health Care Worker will provide the WIC Program with acurrent hemoglobin or hematocrit laboratory value.

9.2. The PCP and/or Women's Health Care Worker will document the laboratory values andthe referral in the member's medical record.

10. Referral to California Department of Health Care Services (DHCS) – certified geneticservices if indicated.

11. Comprehensive nutrition, psychosocial, and health education risk assessment (ideally atinitial visit, but within 4 weeks of initial visit)

12. Development of an Individualized Care Plan

12.1. 8-18 weeks' gestation

12.1.1. Ultrasound if indicated

12.1.2. Amniocentesis if indicated

12.1.3. Chorionic villus sampling if indicated

12.2. 16-18 weeks' gestation

12.2.1. Maternal serum alpha-fetoprotein (by California law, must be offered to allpregnant women entering prenatal care prior to the 20th completed week of gestation)

12.3. By 27 weeks' gestation

12.3.1. Reassessment of nutritional, psychosocial, and health education needs – reviseIndividualized Care Plan as indicated

12.4. 26-28 weeks' gestation

12.4.1. Diabetes screening

12.4.2. Repeat hemoglobin or hematocrit if indicated

12.5. 28 weeks' gestation

12.5.1. Repeat antibody test for unsensitived Rh-negative members

12.5.2. Prophylactic administration of Rho (D) immune globulin if indicated

12.6. 32-36 weeks' gestation

12.6.1. Ultrasound if indicated

12.6.2. Repeat testing for sexually transmitted disease if indicated

12.6.3. Repeat hemoglobin or hematocrit if indicated

12.6.4. Family planning counseling/plan

12.6.5. Offer HIV test again if previously refused or continued high risk health behaviors

12.7. By 39 weeks' gestation

12.7.1. Reassessment of nutrition, psychosocial, and health education needs – reviseIndividualized Care Plan as indicated

12.7.2. Inquiry related to member's plan for pediatric services/provide information aboutChild Health and Disability Program (CHDP) program

12.8. Every prenatal visit

12.8.1. Urine check for glucose and protein

12.8.2. After quickening, report of fetal movement

12.8.3. Blood pressure, weight, uterine size, fetal heart rate, edema, Leopold'smaneuvers

12.8.4. Interval history

12.8.5. Opportunity for questions

12.8.6. Continual risk assessment and revision of the Individualized Care Plan andreferral as indicated

12.9. Postpartum, 4-8 weeks following delivery

12.9.1. Physical exam to include:

12.9.1.1. Breast examination

12.9.1.2. Recto vaginal evaluation

12.9.1.3. Bimanual examination of the uterus and adnexa

12.9.1.4. Weight, blood pressure

12.9.1.5. Abdominal examination

12.9.2. Interval history/adaption to newborn

12.9.2.1. Discussion of normal symptoms versus warning of postpartum depression

12.9.2.2. Family adaptation

12.9.3. Immunization status (especially rubella for non-immune women)

12.9.4. Breastfeeding inquiries

12.9.5. Counseling regarding future health and pregnancies (gestational diabetes,vaginal birth after cesarean, genetic anomalies, hypertension, etc.)

12.9.6. Laboratory data as indicated (hgb if anemic on discharge from hospital, etc.)

12.9.7. Family Planning counseling/prescription

12.9.8. Well child care (CHDP) inquiry/referral

12.9.9. Reassessment of nutrition, psychosocial, and health education needs-revise orclose Individualized Care Plan as indicated

12.9.10. CPSP support services are available to members for up to 6- days postpartum.

12.9.11. Medical, gynecological, nutritional, psychosocial, and/or health education needs/problems persisting beyond this period are communicated to the member's Primary Care Physician for further follow-up and service coordination.(This is accomplished by the transfer of a copy of the Individualized Care Plan, which clearly indicates unresolved

problems/needs, and interventions to date, from the perinatal provider to the PCP).

12.9.11.1. Members will be referred to community resources by the Imperial Health Holdings Medical Group Provider /UM medical staff whenever necessary or appropriate.

At-Risk Pregnancy/Postpartum Conditions

1. Identification of risk factors is critical to minimizing maternal and neonatal morbidity andmortality.

2. The obstetric provider is responsible for the following

2.1. Identifying women with high-risk pregnancy conditions

2.2. Providing appropriate referrals to perinatal specialists

2.3. Coordinating other medically necessary services

2.4. Making appropriate referrals to public health programs, social services and communitysupport agencies at any time during the pregnancy when high-risk indicators are identified.

2.5. Personal supervision of the member's Individualized Care Plan to ensure that all identified risk conditions are followed-up with interventions expected to ameliorate or remedy the condition or problem in a prioritized manner.

2.6. This supervision is the obstetric provider's responsibility whether the support services(nutrition, psychosocial and health education) assessments and interventions are accomplished in his/her practice or are carried out at another location.

3. A case manager is available to assist the provider with the coordination of services.

4. Following is a partial list of factors, derived from the history or physical examination of the member that may increase pregnancy and/or postpartum risk(s) and may necessitate further evaluation, consultation, or referral

4.1. Medical Problems

4.1.1. Cardiovascular, renal collagen, pulmonary, infectious, hepatic, and sexuallytransmitted diseases

4.1.2. Metabolic or endocrine disorders

4.1.3. Chronic urinary tract infections

4.1.4. Maternal viral, bacterial, or protozoal infections

4.1.5. Diabetes mellitus

4.1.6. Severe anemia

4.1.7. Isoimmune thrombocytopenia

4.1.8. Convulsive/neurologic disorders

4.1.9. Substance abuse (e.g., alcohol, tobacco, illicit drugs, over-the-counter, or prescribed medications such as barbiturates, sedatives and anti-depressants

4.2. Obstetric/Genetic Problems

4.2.1. Poor obstetric history

4.2.2. Maternal age under 17 or under 35 years of age

4.2.3. Previous congenital anomalies

4.2.4. Multiple gestation

4.2.5. Isoimmunization

4.2.6. Intrauterine growth retardation

4.2.7. Third-trimester bleeding

4.2.8. Pregnancy-induced hypertension

4.2.9. Uterine structural anomalies (e.g., septum, abnormality caused by in-uteroexposure to diethylstilbestrol)

4.2.10. Abnormal amniotic fluid volume

4.2.11. Fetal cardiac arrhythmias

4.2.12. Prematurity

4.2.13. Breech or transverse lie (intrapartum)

4.2.14. Rupture of membranes for a period of time longer than 24 hours

4.2.15. Chorioamnionitis

4.3. Psychosocial Problems

4.3.1. Inadequate housing

4.3.2. Domestic violence

4.3.3. Absence of adequate psychosocial support

4.3.4. Cognitive deficits

4.3.5. Transportation issues

4.3.6. Excessive worries/fears

4.3.7. Previous pregnancy loss

4.3.8. Severe emotional problems

4.3.9. Eating disorders

4.3.10. History of depression, suicidality, psychosis, hospitalization

4.3.11. Pregnancy complicated be detection of fetal anomaly

4.3.12. Extreme difficulty or resistance to compliance with medicalrecommendations or restrictions

4.3.13. Postpartum depression

4.4. Nutritional disorders/nutritional risk factors

4.4.1. Inadequate (less than 2 lb./month after 1st trimester) or excessive (more than 8lb./month) weight gain

4.4.2. Eating disorders

4.4.3. Tobacco, alcohol, drug, caffeine use

4.4.4. Hematocrit <27%

4.4.5. Hemoglobin <9%

4.4.6. MCV <83 or >95 cu ml

4.4.7. Abnormal 3-hour glucose tolerance test

4.4.8. Presence of glucose, ketones or protein in urine

4.4.9. Pica

4.4.10. No cold food storage or cooking facilities

4.4.11. Less than 3 years since onset of menses

4.4.12. High Parity (5 or more previous deliveries at greater than 20 weeks'gestation)

4.4.13. Excessive use of nutrient supplements

4.4.14. Chronic use of laxatives, antacids, or other over-the-counter drugs knownto affect nutritional status

4.4.15. Use of herbal remedies known or suspected to cause toxic side effects

4.5. Health Education Risk Factors

4.5.1. Substance use

4.5.2. HIV risk status

4.5.3. Noncompliance with medical advice

4.5.4. Failed appointments

4.5.5. Age less than 17 years of age or greater than 35 years of age

4.5.6. Late initiation of prenatal care

4.5.7. Primagravida or grand multipara

4.5.8. Previous pregnancy problems

4.5.9. Nutritional status indicators

4.5.10. Occupational risk

4.5.11. Diabetes

4.5.12. Hypertension/Pregnancy-induced hypertension

4.5.13. Cardiovascular problems

4.5.14. Hepatitis

4.5.15. Tuberculosis

4.5.16. STD history

4.5.17. Uterine problems

4.5.18. Kidney problems

4.5.19. Pulmonary disease

4.5.20. Epilepsy

4.5.21. Hematologic disorders

4.5.22. Preterm labor

4.5.23. Eating disorders

4.5.24. Mental disabilities

4.5.24.1.1. Physical disabilities

4.5.24.1.2. Inability to read or low reading

level4.5.24.1.3. Language barriers

4.5.24.1.4. Low educational

level4.5.24.1.5. Low motivation

4.5.24.1.6. Negative attitude about pregnancy

4.5.24.1.7. Little or no prior experience with western medicine/health

care4.5.24.1.8. Lack of social support structure

4.5.24.1.9. Inability to reach decisions/comprehension

difficulties4.5.24.1.10. Extreme anxiety or emotional problems

4.5.24.1.11. Transportation challenges

4.5.24.1.12. Family problems/abuse

4.5.24.1.13. Economic/housing

needs4.5.24.1.14. Informed consent needs

4.5.24.1.15. Other children not linked to well child care resources

4.5.24.1.16. Lack of knowledge related to management of common pregnancyand post-partum conditions/discomforts

Referral Process

1. The provision of the full scope of CPSP services to pregnant Members is the responsibilityof all participating, DHCS-certified CPSP providers. IHHMG recognizes the advantages ofenlisting the services of CHS-certified CPSP providers and will endeavor to link pregnant members to participating CPSP certified providers.

1.1. The CPSP certification is verified on an annual basis.

1.2. DHCS-certified CPSP providers are responsible for complying with policies, proceduresand standards including the use of approved assessment and documentation tools.

2. Health care workers who perform CPSP support services assessments and interventionsmeet Title 22, California Code of Regulations (CCR), Section 51179.7 standards for Comprehensive Perinatal Practitioners which include:

2.1. Physician

2.1.1. General practice

2.1.2. Family practice

2.1.3. Pediatric practice

2.1.4. Obstetrics/gynecology practice

2.2. Certified Nurse Midwife

2.3. Registered Nurse

2.3.1. Licensed by the Board of Registered Nursing, and

2.3.2. One-year experience in the field maternal and child health

2.4. Nurse Practitioner

2.5. Physician Assistant

2.6. Social Worker

2.6.1. Baccalaureate Degree or higher in social work or social welfare from a college oruniversity with a social work degree program accredited by the Council on Social Work Education and who has one-year experience in the field of maternal and childhealth, or

2.6.2. Master's Degree in psychology or Marriage, Family and Child Counseling andhas one year of experience in the field of maternal and child health.

2.7. Health Educator

2.7.1. Baccalaureate degree or higher in Community or Public Health Education

2.7.2. One year of experience in the field of maternal and child health

2.8. Childbirth Educator

2.8.1. Licensed Registered Nurse with one-year experience in a program whichcomplies with ACOG's "Guidelines for Childbirth Education" (1981), or

2.8.2. Certified by the American Society for Psychoprophylaxis in Obstetrics, Bradley,or the International Childbirth Education Association.

2.9. Dietician

2.9.1. Registered or eligible to be registered by the Commission on Dietetic Registration with one-year experience in the field of maternal and child health

2.10. Comprehensive Perinatal Health Worker

2.10.1.1. At least 18 years of age

2.10.1.2. High school graduate or equivalent

2.10.1.3. One year of full-time paid practical experience in proving perinatal care

2.10.1.4. Providers services in a clinic that is either licensed or exempt fromlicensure

2.10.1.5. Under direct supervision of comprehensive perinatal practitioner

2.11. Licensed Vocational Nurse

2.11.1.1. One year of experience in the field of maternal and child health

3. Participating, non-DHCS-certified CPSP providers are required to develop formal agreements with CHS-certified CPSP providers to ensure that all pregnant women have access to care in accordance with this policy. The required services include:

3.1. Client orientation

3.2. Obstetrical services

3.3. Nutrition, psychosocial, and health education support services initial assessments

3.4. Formal reassessments each subsequent trimester and in the postpartum period

3.5. Development of an Individualized Care Plan to include planned interventions as indicated by the assessments, and outcome objectives for each of the four categorieswith revision as needed, but at least for each subsequent trimester and postpartum

3.6. Case coordination

3.7. Vitamin/mineral supplementation

3.8. Referral to Women, Infants, and Children (WIC) Supplemental Nutrition Program

3.9. Provision of or referral for dental, genetic, family planning and well child care (CHDP)services, as indicated.

4. DHCS-certified CPSP providers who enter into agreements to provide CPSP support

services for non-DHCS-certified providers are responsible for providing all support services as listed above in addition to recommending appropriate referrals to the obstetric provider for support services. Additionally, the contracted CPSP support service provider is responsible for trimester and postpartum reassessments, provision of or arrangement for appropriate nutrition, psychosocial, and health education interventions, Individualized CarePlan revision, and case coordination including organizing case conferences when appropriate.

4.1. Obstetric care providers' agreements with DHCS-certified CPSP providers for the rendering of CPSP support services to their pregnant members must include the following components. Obstetric providers and CPSP support services responsibilities:

4.1.1. Provide for all obstetrical care including antepartum, intrapartum, and postpartumcare

4.1.2. Bill for all obstetric care (if applicable)

4.1.3. Prescribe prenatal vitamins to be distributed through and billed for by CPSPprovider

4.1.4. Refer all pregnant members to the CPSP support services provider. When indicated, referrals to Registered Dietician, Social Workers, Health Educators orother support services providers.

4.1.5. Fee-for-Service Providers obtain authorization for referrals through the UtilizationManagement Department.

4.1.6. Provide a copy of all antepartum exams, labor and delivery experience and postpartum exam to CPSP support services provider to be included in CPSP chart

4.1.7. Include copies of all assessments, reassessments, Individualized Care Plan, andother documentation related to interventions provided by CPSP support services provider in the medical chart.

4.1.8. Provide the CPSP orientation

4.1.9. Provide initial support services assessment, develop Individualized Care Plan, provide trimester and postpartum reassessments, provide/coordinate interventionsand case coordination services to pregnant members enrolled in CPSP upon referral from the named obstetric provider

4.1.10. Bill for all CPSP services

4.1.11. Provide copy of assessments, reassessments and intervention documentation on monthly basis to obstetric provider for inclusion in obstetricmedical record

4.1.12. Bill for distribution of prenatal vitamins and minerals upon delivery of 300-day supply to the member as prescribed by obstetric provider

4.1.13. Include copies of obstetric exams, labor and delivery experience andpostpartum exam in CPSP chart as received from obstetric provider.

4.2. The Individualized Care Plan must comply with the following requirements:

4.2.1. Obstetrical component includes the prevention and/or resolution ofobstetrical/medical problems.

4.2.2. Nutrition component includes the prevention and/or resolution of nutrition problems; the support and maintenance of strengths and habits oriented towardoptimal nutrition status, and the goals to be achieved.

4.2.3. Psychosocial component includes the prevention and/or resolution of psychosocial problems; the support and maintenance of psychosocial strengths;and, the goals to be achieved.

4.2.4. Health Education component includes

4.2.4.1. The member's health education strengths

4.2.4.2. The prevention and/or resolution of health education problems

4.2.4.3. The needs and medical conditions

4.2.4.4. The health promotion/risk reduction behaviors

4.2.4.5. The goals to be achieved via health educator intervention based on themember's needs, interests, and capabilities.

4.2.5. Examples of client strengths include, but are not limited to:

4.2.5.1. Ability to comprehend and make decisions

4.2.5.2. Ability to cope

4.2.5.3. Adequate food

4.2.5.4. Adequate shelter/clothing

4.2.5.5. Adequate transportation

4.2.5.6. Emotionally stable

4.2.5.7. Employed

4.2.5.8. Experience/knowledge of labor and delivery

4.2.5.9. Experience/knowledge of infant care

4.2.5.10. Experience/knowledge of parenting

4.2.5.11. Financially stable

4.2.5.12. Positive compliance

4.2.5.13. Positive school education

4.2.5.14. Interest/willingness to participated in individual/group classes

4.2.5.15. Motivation

4.2.5.16. Access to refrigerator/stove

4.2.5.17. Social support system

4.2.5.18. Thinking of the future

4.2.5.19. Wanted/accepted/planned pregnancy

4.3. Care Managers are available to coordinate care with other case management agenciessuch as Black Infant Health, Prenatal Care Guidance, Public Health Nursing, and Adolescent Family Life/Cal-Learn Programs, to ensure appropriate resources are available to the member and to avoid duplication of services.

5. The local Perinatal Services/CPSP Coordinator ensures that all DHCS-certified CPSP providers receive all DHCS-sponsored CPSP updates, as well as a copy of the CPSP Enhancement, "Steps to Take" materials, which provide information helpful to CPSP approved staff to effectively assess, provide interventions (for common pregnancy conditions and discomforts, not for high risk situations) and appropriately refer pregnant members.

<u>Access to Care</u>

1. IHHMG evaluates access to perinatal related services by reviewing selected claims

andencounter data. Utilizing this data, IHHMG identifies opportunities to identify members

early in their pregnancy and link them to appropriate perinatal programs and services, including CPSP.

2. Access to prenatal care is an important factor in achieving healthy birth outcomes.

3. IHHMG will attempt to coordinate transportation through volunteer groups, communityagencies, and local health department programs when necessary.

Intrapartum Care

1. Pregnant members are informed of a designated facility for delivery.

1.1. The choice of facility is based on risk-appropriateness as well as contractualarrangements.

1.1.1. This information should be reconfirmed and reinforced with the member duringthe course of prenatal care.

1.1.2. The obstetric provider forwards a copy of the member's prenatal care records tothe designated facility per facility procedures.

2. Women and high-risk pregnancies are directed to a facility with advanced obstetrics andneonatal care units.

2.1. If the need for Neonatal Intensive Care Unit (NICU) services is anticipated (prematurity,known congenital anomaly, low estimated fetal weight, diabetic pregnancy, maternal cardiac or other diseases, etc.), high risks members must be instructed to deliver in a hospital with an appropriate level CCS-designated NICU. Refer to Policy and Procedure related to California Children Services (CCS).

3. The following conditions require specialized care and the member should be directed to goto, or be transferred prenatally to, a facility with a California Children Services (CCS) designated NICU with the capacity to provide risk-appropriate care for their delivery and new born

3.1. Maternal/Obstetrical Complications

3.1.1. Intermediate, Community or Regional NICU Designation recommended

3.1.1.1. Premature rupture of membranes, 32-34 weeks' gestation

3.1.1.2. Premature labor <36 weeks but > 32 weeks' gestation

3.1.1.3. Twins or triplets at 34-38 weeks' gestation

3.1.1.4. Hydrops Fetalis

3.1.2. Community or Regional NICU Designation recommended

3.1.2.1. Intrauterine growth retardation

3.1.2.2. Premature rupture or membranes <32 weeks' gestation/unknown dateswith estimated fetal weight 2,000 grams

3.1.2.3. Premature labor <32 weeks' gestation/unknown dates with estimated fetalweight 2,000 grams

3.1.2.4. Trauma requiring intensive care or surgical corrections or requiring aprocedure that may result in the onset of premature labor

3.1.2.5. Acute abdominal emergencies

3.1.2.6. Preeclampsia, eclampsia, or other hypertensive complication

3.1.2.7. Third-trimester bleeding

3.1.2.8. Multiple gestation <34 weeks' gestation and all >3 fetuses

3.2. Medical Complications

3.2.1. Infections

3.2.2. Heart disease

3.2.3. Diabetes mellitus

3.2.4. Thyrotoxicosis

3.2.5. Renal disease with deteriorating function or increased hypertension

3.2.6. Hepatic disease

3.2.7. Drug overdose

3.3. Fetal Conditions

3.3.1. Anomalies that may require surgery

3.3.2. Congenital anomalies requiring specialized newborn care

3.3.3. Erythroblastosis requiring intrauterine transfusion

3.4. Neonatal Conditions where transport may be indicated

3.4.1. Gestation less than 32 weeks or weight less than 1,500 grams

3.4.2. Persistent respiratory stress

3.4.3. Seizures refractory to usual treatment

3.4.4. Congenital malformations requiring special diagnostic procedures or surgicalcare

3.5. Dequelae of hypoxia persisting beyond two (2) hours, with evidence of multisysteminvolvement

3.5.1. Cardiac disorders that require special diagnostic procedures or surgery

3.5.2. Sepsis

4. Care Managers remain available to the provider throughout the continuum of the prenataland postpartum periods for resource identification and coordination of health care and human services.

Quality Management

1. Study results and quality improvement activities are reported to the Quality ManagementCommittee.

2. Quality Management and other departments work to improve compliance and ultimately,health outcomes including but not limited to oversight audits.

3. Peer Review audits will be coordinated and analyzed by the Quality Improvement andDisease Management Departments to ensure compliance.

4. The Health Education Department (HED) will keep abreast with CPSP protocols as part ofmeeting Title XXII regulations.

4.1. The HED will update, revise and distribute the CPSP protocols to CPSP providers,health workers and monitoring departments.

4.2. The HED will submit customized CPSP protocols to the Department of Health Servicesfor review and approval as required.

5. The CPSP protocols will be reviewed, discussed and approved annually by the QualityManagement Committee and Board of Directors

Reference(s)

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	
Policy Number(s): 10-007	**Orig. Date:** 05/01/16
Effective Date: 07/16/21	**Revision(s) Date:** 07/16/21
MSC Committee Approval: **Date:** 07/29/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 07/29/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE
Imperial Health Holdings Medical Group Utilization Management Staff, PCP, Specialists, CM Staff (if Delegated).

PURPOSE
To have a written policy and procedures for referral process for members under 21 years of age as defined in title 22, CCR Section 51184, except when EPSDT services are provided as CCS services pursuant to Exhibit A, attachment 11, provision 8 regarding CCS services or as Mental Health services pursuant to provision 7, regarding mental health services.

POLICY
1. IHHMG arranges for the provision of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), supplemental services, as such services defined in Title 22, California Code of Regulations (CCR), Section 51184 and MMCD Policy Letter No. 96-07. except when EPSDT services are provided as CCS services pursuant to Exhibit A, attachment 11, provision 8 regarding CCS services or as Mental Health services pursuant to provision 7, regarding mental health services.

   1.1 Developmental surveillance occurs during every periodic pediatric health visit.

   1.2 Developmental screening is done using standardized developmental screening tools during the periodic pediatric health visits at 9 months, 18 months and 30 months.

2. The Case Manager ensures that patient/participant/clients under the age of 21 years who qualify for EPSDT supplemental case management services are rendered by their PCP to a targeted case management program under contract with a local government agency, or to an entity, such as Regional Centers, that provides case management services. When EPSDT case management services are rendered by these referral providers, the Case Manager and Medical Director determine the medical necessity criteria of diagnostic and medical treatment services.

3. The Case Manager is responsible for comprehensive care management services. If EPSDT case management services are not available from these referral providers, IHHMG arranges and reimburses for all appropriate EPSDT supplemental services. All EPSDT supplemental services are subject to review by the Medical Director.

4. EPSDT supplemental services are those medically necessary services, including EPSDT case management services that not available to the Medi-Cal population over age 21 and not provided through the Medi-Cal program. EPSDT case management services are those services that will assist EPSDT-eligible individuals in gaining access to needed medical, social, educational, and other services.

EPSDT Supplemental Services

IHHMG identifies EPSDT supplemental services as those medically necessary services that are not available to the Medi-Cal population over age 21. The definition of medical necessity is based on the standards set forth in MMCD Policy Letter No. 96-07. PCPs identify patient/participant/clients in need of EPSDT supplemental services as part of the health assessment system. Additionally, the need for services may be identified by the patient/participant/client, the patient/participant/client's parents/guardian, the county Child Health and Disability Prevention (CHDP) Program, or through an encounter with another health professional.

There are three criteria that determine if EPSDT supplemental services are medically necessary:

1. The requested EPSDT supplemental service can meet the existing criteria for medical necessity applicable to services that are available to the general Medi-Cal population;

2. The requested EPSDT supplemental service can meet distinct, EPSDT supplemental service specific requirements.

3. If criterion number one above is not met, and if criterion number two above is not applicable to the service, then the requested EPSDT supplemental service must be evaluated under the expanded medical necessity criteria established in the EPSDT regulations in Title 22, CCR, Section, Section 51340(e)(3), as summarized below:

   3.1 The services are intended to correct or ameliorate defects or physical and/ormenta illnesses or conditions identified through screening.

   3.2 The supplies, items, or equipment to be provided are medical in nature.

   3.3 The services are not requested solely for the convenience of the patient/participant/client, family, physician, or other provider of services.

   3.4 The services are not primarily cosmetic in nature or primarily to improve patient/participant/client's appearance.

   3.5 The services are safe and not experimental and are recognized as anaccepted modality of medical practice.

3.6 Where alternative medically accepted modes of treatment are available, the EPSDT supplemental services must be the most cost effective. IHHMG may determine the most cost-effective setting for services on a case-by-case basis. Where the determination of cost-effectiveness involves an assessment of services not covered by the Health Plans (e.g., home-and community-based waiver services or long-term care in a nursing facility), IHHMG must coordinate the determination of cost effectiveness with the Department of Health Care Services (DHCS).

3.7 The services to be provided must be generally recognized as an accepted modality of medical practice or treatment, be within the authorized scope of practiceof the provider and be an appropriate mode of treatment for the medical treatment for the medical condition of the patient/participant/client.

3.8 There is scientific evidence, consisting of well-designed and conducted investigations published in peer-reviewed journals, demonstrating that the service can produce measurable psychiatric services, measurable psychological outcomes concerning the short and long-term effects of the proposed services. Opinions and evaluations published by national medical organizations, consensus panels, and other technology• evaluation bodies supporting provision of the benefit shall also be considered when available.

3.9 The predicted beneficial outcome of the service outweighs potential harmful effects.

3.10 The services improve the overall health outcomes as much as, or more than, established alternatives.

Provider Qualification

Any EPSDT Case Manager must meet the standards for EPSDT supplemental service providers set forth in the EPSDT regulations of Title 22, CCR, Section 51242. Generally, an EPSDT supplemental services provider must be licensed or certified under state laws governing the healing arts to provide services, or if such licensure or certification is not available under state laws, the provider must be otherwise authorized under state laws governing the healing arts to provide service. A provider who is currently enrolled as a Medi-Cal service provider shall not be required to enroll as an EPSDT supplemental services provider. IHHMG ensures that providers meet standards for participation in the Medi-Cal program. IHHMG is not obligated to ensure that such providers are enrolled in the Medi-Cal program.

PROCEDURE

1. Referrals

1.1. PCPs identify patient/participant/clients in need of EPSDT supplemental services as part of the initial health assessment system. Additionally, the need for services may be Identified by the patient/participant/client, the patient/participant/client's parents/guardian, the county CHDP Program, or through an encounter with another healthprofessional. All referrals for EPSDT supplemental services are directed to Case Management for initial screening. Patient/participant/clients potentially eligible for EPSDT supplemental services are reviewed by the Medical Director for medical necessity and authorized accordingly. When EPSDT supplemental services are authorized, comprehensive care management requirements are also assessed.

1.2. Specialty mental health services outside the scope of practice of the PCP, alcohol and drug services, and dental services are all referral services. IHHMG excludes all psychotherapeutic drugs prescribed by psychiatrists from coverage. IHHMG is obligated by contract with the DHCS to "provide all psychotherapeutic drugs prescribed by its primary care physicians." Medications related to the treatment of dental infection and forpain control such as antibiotics and IHHMG cover analgesics, but routine dental medications such as gels, etc. are not.

2. Care Management Coordination

2.1. The Case Manager and Medical Director review requests and determine the medical necessity of EPSDT supplemental services using the criteria established in Title 22, CCR, Section 51340. The Case Manager follows-up with the Patient/participant/client's PCP to ensure that referrals are made to appropriate agencies and programs.

2.2. Following review and authorization from the Medical Director, the Case Manager coordinates the service. The authorization is maintained in the Medical Management database which interfaces with the claims processing system to accelerate processing ofthe claim.

2.3. The Case Manager issues letters of authorization and negotiated claims payment instruction to EPSDT supplemental providers.

2.4. The Case Manager continues to provide care management and updates the care management plan as necessary.

2.5. Services to be determined to be medically necessary for treatment or amelioration of the CCS Covered condition, including Private Duty Nursing related to CCS eligible conditions must be case managed and have obtained prior authorization by the CCS Program (on a FFS basis), Title 22, CCR, Section 51013)

3. Documentation

The medical record will reflect the following regarding EPSDT case management services:

3.1 Patient and family education regarding EPSDT program and supplemental

3. 2 Documentation that referral to EPSDT case management services is appropriate

3.3 Reason for referral

3.4 Patient of family reply to referral

3.5 Subsequent care plan

Reference(s)

Title 22, CCR Section 51013

Title 22, CCR Section 51184

DHCS APL 20-12

Attachments:

None

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department

Policy Title: Family Planning	
Policy Number(s): 10-008	**Orig. Date:** 05/01/16
Effective Date: 10/12/22	**Revision(s) Date:** 10/12/22
MSC Committee Approval: **Date:** David MK Liu **11/10/22**	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: **Date:** Josie Wong **11/10/22**
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Plan and Imperial Health Holdings Medical Group, shall follow the procedures set forth in this policy.

PURPOSE

To establish a standardized, consistent, and timely process and access to the full array of family planning services from any qualified family planning provider in-or-out-of-network, asdescribed in the Health Plan benefits.

To ensure a clear understanding that Members have the right to access Family Planning services through any Family Planning provider without Prior Authorization. The IPA shall inform its Members in writing of their right to access any qualified family planning providerwithout prior authorization.

- Family Planning services are provided to members of childbearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration.
- Members of childbearing age may access the following services from out of plan family planning providers to temporarily or permanently prevent or delay pregnancy:

POLICY

IHHMG provides all of its membership timely access to the full array of family planning services from any qualified family planning provider without prior authorization in accordance with the 1987 Omnibus Reconciliation Act, Medi-Cal or Health Plan Contract, Title 22 and

MMCD Policy Letters #94-13, #95-03 and #98-11, and AB 525 (1/1/01). Members may accessfamily planning services from any qualified provider, including their Primary Care Physician (PCP) and other participating and nonparticipating (out-of-plan) providers. An out-of-plan family planning provider is defined by the California Department of Health Services as "a qualified provider who is licensed to furnish family planning services to a Member as specified in Title 22. Section 512 services within their scope of practice, is an enrolled Medi-Cal provider,and is willing to furnish family who is not employed by, under contract with, or otherwise affiliated with the Plan for authorized referral services."

Participating and non-participating providers are encouraged to coordinate services with the member's PCP to ensure continuity and avoid duplication.

PROCEDURE

1. Available Services

1.1. Members are entitled to receive the full array of family planning services from any qualified family planning provider. Absent clinical contraindications, IHHMG will not impose utilization controls limiting the supply of FDA-approved, self-administered hormonal contraceptives dispensed or furnished by a provider, pharmacist, or other authorized location to an amount that is less than a 12-month supply. The followingfamily planning services will be available to all members of childbearing age to temporarily or permanently prevent or delay pregnancy:

1.1.1. Health education and counseling necessary to make informed choices andunderstand contraceptive methods.

1.1.2. Limited history and physical examination

1.1.3. Medically indicated laboratory tests as part of decision-making process to choosea contraceptive method

1.1.4. Follow-up care for complications related to contraceptive methods issued by thefamily planning provider

1.1.5. Confidential counseling and testing for HIV and referral for treatment when consistent with "HIV Counseling, Testing and Referral Standards and Guidelines,"published by the U.S. Public Health Service and MMCD Policy Letter 97-08.

1.1.6. Two visits maximum for follow-up care for complications clearly and directly associated with the contraceptive method(s) issued by a non-participating familyplanning provider.

1.1.7. Provision of up to a 12-month supply of oral contraceptive pills, hormone-containing contraceptive transdermal patches, or hormone-containing

contraceptive vaginal rings when dispensed at one time at a member's request bya qualified family planning provider or pharmacist, including out-of-network providers.

1.1.8. Diagnosis and treatment of sexually transmitted diseases (one visit per episodewhen provided by non-participating provider) in accordance with MMCD Policy Letter 96-09.

1.1.9. Vasectomies

1.1.10. Pregnancy testing and counseling

1.1.11. Pregnancy Termination

1.1.12. Tubal ligation

2. Member Education on Family Planning Services

2.1. Family planning benefits available to members through participating and non-participating providers without referral or prior authorization.

2.1.1. A complete list of the family planning services offered and descriptions oflimitations on the family planning services members may seek from non-participating provider.

2.1.2. The member's freedom to choose a qualified participating or non-participatingfamily planning provider.

2.1.3. The member's right to confidentiality of medical information and personal data.

2.1.4. The member's right of access to confidential and sensitive services, including the availability of minor consent services.

2.1.5. The positive impact of coordinated care on health outcomes.

3. Provider Education on Family Planning Services and Procedures

3.1. Conducts annual educational forums for participating providers and provide additional information through provider bulletins, the Provider Manual, and physician newsletter.

3.2. Visit providers in their offices to distribute tools and educational materials and to confirm those appropriate resources.

4. Member's Access to Family Planning Services from the PCP

4.1. Members may access family planning services by calling their PCP and making an appointment.

5. Member Access to Family Planning Services from Non-Participating Providers

5.1. Members may access family planning services by calling the provider, making an appointment and providing the center or physician's office staff with the member's ID number.

5.2. Non-participating family planning providers may call IHHMG for eligibility, benefit andbilling information.

5.2.1. Upon an inquiry by a family planning provider, the Utilization ManagementDepartment evaluates the call and opens a log.

5.2.2. IHHMG will provide the family planning provider with eligibility, benefit and billinginformation as well as the member's PCP name and phone number to promote the coordination of services and any necessary follow-up care as to avoid duplication of services.

5.2.3. Family planning services providers may also use the Medicare, Medi-Cal and/orCommercial eligibility verification options available to them.

5.2.4. It is the responsibility of the family planning provider to obtain the P/P/C's a written consent to request copies of medical records, as necessary, from the member's PCP.

5.2.5. It is the PCP's responsibility to forward appropriate medical records to the familyplanning services provider within 30 calendar days of receipt of an appropriate medical record release form signed by the member.

5.2.6. If a non-participating provider requests intercession from IHHMG because the PCP has not forwarded previously requested records, the Case Manager will coordinate record transfer as rapidly as possible, not to exceed 10 working days.

5.2.7. It is the responsibility of the family planning services provider to inform health plan member about the importance of coordination of care and the possibility thatthe member will be referred back to their PCP for the treatment of unusual complications of a family planning method.

5.2.8. If confidentiality is not an issue to the member, non-participating family planning services providers should refer the member to participating pharmacies and laboratories for covered services.

5.3. A member may request a Sensitive Service Confidential Communication (SSCC) concerning communication related to any sensitive services. Confidentiality must be protected regardless of method of requested communication; this may include information sent to an alternative

location.

5.4. Provider Organization does not require parental consent for children 12 years and older to obtain Sensitive Services.

5.5. Provider Organization does not inform parents or legal guardians of a minors Sensitive Services care and information without minors permission, except as Allowed by law.

5.6. The Nurse is available to assist the family planning services provider or the PCP should any concerns, including the provision of timely services and referrals, arise during the care of the member.

5.7. Nurse Management is available to assist providers and member when issues arise concerning the ability to access timely access.

5.8. The Utilization Management Department tracks all grievances related to access to family planning services received by IHHMG. In addition, the grievances are report tothe Plan in the required timeline when not delegated to IHHMG.

Reference(s)

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATIVE SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Genetic Screening as part of prenatal (OB) services- Genetic Counselling	
Policy Number(s): 10-009	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management staff, PCP, Specialists

PURPOSE

In order to assure optimum perinatal care and pregnancy outcomes for Medi-Cal managed care enrollees (Members), Medi-Cal managed care plans (Plans) must meet the provisions setforth in Policy Letter # 12-003.

POLICY

All Plans must ensure initiation of prenatal care as soon as possible and must not require prior authorization for basic prenatal care or preventive services. Plans must inform Members of childbearing age of the availability of comprehensive perinatal services and how to access such services as soon as pregnancy is determined.

Genetic Counseling is intended to provide members who have a genetic disease or are at risk of such a disease with information about their condition and its effect on their family. This allows patient/participant/clients and their families to make informed reproductive and other medical decisions. The counselor will evaluate medical problem or risks present in a family, analyze and explain inheritance patterns of any disorders found, provide information about management and treatment of these disorders, and discuss available options with thefamily or individual.

PROCEDURE

Genetic counseling in connection with pregnancy management or family planning to evaluate any of the following:

1. Parents of a child born with a genetic disorder, birth defect, inborn error ofmetabolism or chromosome abnormality.

2. Parents of a child with mental retardation, autism, developmental delays, or learning disabilities.

3. Pregnant women with maternal age 35 years or greater at delivery.

4. Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told that their pregnancy maybe at increased risk for complications or birth defects.

5. Pregnant women, or women planning pregnancy, exposed to potentially teratogenic,mutagenic or carcinogenic agents, (i.e. drugs, chemicals, radiation, infections).

6. When contemplating pregnancy, either parent affected with an autosomaldominant disorder.

7. Mother, known, or presumed carrier of an X-linked recessive disorder.

8. Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more amonginfertile couples) first trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities.

9. Infertility cases where either parent is known to have a chromosomal abnormality.

10. Individuals from ethnic groups recognized to be at increased risk for specific genetic disorders (e.g., African-Americans for sickle cell anemia, Ashkenazi (Eastern European) Jews for Tay-Sachs disease).

11. Familial cancer disorders.

IHHMG ensures initiation of prenatal care as soon as possible and must not require prior authorization for basic prenatal care or preventive services. IHHMG shall inform its Membersof childbearing age of the availability of comprehensive perinatal services and how to accesssuch services as soon as pregnancy is determined.

Prenatal care coverage and provision of all medically necessary services for pregnant womenshall be provided

IHHMG shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services.

IHHMG ensures that a comprehensive risk assessment tool for all pregnant Members that is comparable to ACOG and the Comprehensive Perinatal Services Program (CPSP) standards (California Code of Regulations, Title 22, Section 51348). Individualized care plans must be developed to include obstetrical, nutrition, psychosocial, and health education interventions when indicated by identified risk factors- See C.P.S.P. Policy # 05-004.

IHHMG ensures that pregnant women at high-risk of poor pregnancy outcomes are referred toappropriate specialists, including perinatologists, and that they have access to genetic screening with appropriate referrals. IHHMG also ensures that appropriate hospitals are available within the provider network to provide necessary high-risk pregnancy services.

IHHMG informs its Providers of the availability of CPSP training opportunities and materials.The following link is made available to the IHHMG Providers:

http://www.cdph.ca.gov/programs/CPSP/Pages/default.aspx.

Reference(s)
This Policy Letter (PL) supersedes the Medi-Cal Managed Care Division's (MMCD)PLs 12-001 and 96-01.

http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2012/PL12-003.pdf

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Minor Consent Services	
Policy Number(s): 10-010	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management staff, PCP's, Specialists,Contracted Inpatient and Outpatient facilities

PURPOSE

The purpose of this policy is to document a clear understanding and policy in the provision of services as described in which minors would not require parental consent for services.

California Family Code provides that a minor may, *without parental consent*, receive services related to sexual assault, pregnancy and pregnancy-related services, family planning, sexually transmitted diseases, drug and alcohol abuse, and outpatient mental health treatment and counseling.

POLICY

Minor consent services are categorized by age as follows:

1. UNDER **AGE 12:**

    1.1. pregnancy and pregnancy-related care

    1.2. family planning services

1.3. sexual assault services

2. AGE **12** YEARS AND OLDER:

2.1. sexually transmitted diseases treatment

2.2. drug and alcohol abuse treatment/counseling

2.3. mental health outpatient care

2.4. pregnancy and pregnancy-related care

2.5. family planning services

2.6. sexual assault services

PROCEDURE

Methadone treatment, psychotropic drugs, convulsive therapy, psychosurgery, and sterilizationare excluded from the services which a minor may receive without parental consent. The above-named services which a minor may receive on his/her own will be referred to as "minor consent services."

The Medi-Cal regulations and procedures are different for minor consent Medi-Cal coverage than they are for full-scope Medi-Cal coverage in the areas of: parental informing of the child's need for medical care, parental consent to Medi-Cal coverage for the child, parental consent tomedical treatment of the child, and parental financial responsibility for the child's medical costs.

State law provides that persons under 21 years may apply for minor consent services Medi-Calwithout their parents' consent or knowledge. The statute further provides that the parents shall not be required to contribute to the cost of minor consent services. However, the parents' income and property must be considered in the eligibility determination for Medi-Cal if the childrequests other medical services not covered under minor consent services.

State law requires that the parents or guardians of a minor receiving outpatient mental health treatment or counseling, or services for drug or alcohol related problems be contacted and encouraged to participate in the treatment. The parents or guardian may not be contacted if the health care professional treating the minor believes it would not be advantageous to the minor to have parents or guardian involved. If the parents or guardian do participate in the treatment, they are required to pay for their share of any services they participate in - i.e., family counseling or individual/couples counseling for the parent).

Although all minor consent cases are confidential, the parents' or guardian's knowledge of theirchild's circumstance in no way affects eligibility for minor consent services, and no contact shall be directed to the parents or guardian.

A minor must apply for minor consent services. Parents cannot apply on behalf of their minor child.

However, one parent may accompany a minor to apply for minor consent services when thereis a need or desire to maintain confidentiality with the other parent. The confidentiality requirement is not waived in this situation. Notices of Action (NOASs) shall not be sent to the home address, etc.

Reference(s)
http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c183.pdf

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Human Sterilization	
Policy Number(s): 10-011	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:** 09/01/19
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management staff, PCP, Specialists,Practitioners, Inpatient and Outpatient facilities

PURPOSE

To ensure that the IHHMG members has sufficient information to make an informed and meaningful consent when undergoing elective sterilization.

POLICY

It is the policy of Imperial Health Holdings Medical Group that all Practitioners must obtain an informed consent for sterilization procedures, including hysterectomies and vasectomies, and must comply with all legal requirements for providing its members with the appropriate and necessary information and documentation as required by law.

PROCEDURE

1. The member to be sterilized is at least 21 years of age at the time the consent for sterilization is obtained, is not mentally incompetent, is able to understand the content andnature of the informed consent process, and is not institutionalized and has signed and dated the consent form.
2. Sterilization procedures will not be performed on members under twenty-one (21) years ofage.

3. The practitioner or designee must discuss and explain the procedure to the member

anddocument this discussion in the member's medical record.

4. A copy of the DHCS Booklet on Sterilization is provided to the patient by either a physicianor by the physician's designee, as part of the Informed Consent process for Sterilization prior to the member signing the PM 330 Consent form.

5. The provision of the DHCS Booklet on Sterilization is documented in the medical record.

6. An approved consent form must be signed and dated by the member after the abovediscussion has taken place.

7. An interpreter, if one is used, must also sign the form, verifying his/her part in the discussion.

   7.1. The Informed Consent may not be obtained while the member to being sterilized or isUnder the reasonably identifiable influence of alcohol or other substances that affect a person's state of awareness.

   7.2. In labor, or within 24 hours postpartum or post abortion, or seeking to obtain an abortion

8. The consent form must be signed at least 30 days, but no more than 180 days before theprocedure is performed, except in cases of premature delivery or emergency abdominal surgery.

   8.1. Sterilization may be performed at such times if

      8.1.1. The P/P/C consented to sterilization at least 30 days prior to the intended dateof sterilization or the expected date of delivery.

      8.1.2. 72 hours has passed between the time the written Informed Consent and theemergency surgery or premature delivery has taken place.

9. A member sterilization procedure log must be maintained and be available for review.

10. Practitioners are to complete the PM 330 Consent for Sterilization Form as Required byLaw

    10.1. The PM 330 forms will be readily available to the practitioners.

    10.2. The PM330 consent form is completed and signed 30 days prior to theprocedure and is reviewed at the time of claims payment.

Reference(s)

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATIVE SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: STD Incidence	
Policy Number(s): 10-012	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP, and Specialist shall follow the procedures set forth in this policy.

PURPOSE

IHHMG provides access to care for sexually transmitted diseases (STDs) without prior authorization both inside and outside of its network.

POLICY

1. Each participating Primary Care Physician (PCP) is responsible to report the identificationof STDs to the local health department (LHD) within the specific timetable as required by Title 17, California Code of Regulations (CCR), Section 2500, "Reporting to the Local Health Authority."

2. In accordance with federal law 1987 O B R A Section 4113(c)(1)(B), Medi-Cal, Cal- MediConnect members are allowed freedom of choice of providers when seeking STD services and, therefore, may receive STD services from any qualified provider, includingout-of-plan providers, without prior authorization. STD services that are provided by participating physicians include education, prevention, screening, counseling, diagnosisand treatment. All IHHMG employees and participating physicians maintain strict confidentiality of member information (PHI).

3. IHHMG acknowledges the provisions of MMCD Policy Letter No. 96-09 in general, and Section IV(c)(2) which limits IHHMG's out-of-plan reimbursement obligation to the termsof the applicable requirements of the contract between IHHMG and the

Department of Health Care Services (DHCS). IHHMG will reimburse STD providers at the Medi-Cal

Fee for Service (FFS) rate, unless otherwise negotiated. IHHMG will provide reimbursement only if STD treatment providers include treatment records, or documentation of the member's refusal to release medical records to IHHMG along with billing information.

4. IHHMG shall ensure all females less than 21 years of age, who have been determined tobe sexually active, are screened for Chlamydia. In the event the member voluntary refuses, the refusal shall be noted in the member's medical record.

5. Members may access LHD clinics and family planning clinics for diagnosis and treatment ofa STD episode. For community providers other than LHD and family planning providers, out-of-plan services are limited to one office visit per disease episode for the purposes of:

5.1. diagnosis and treatment of vaginal discharge and urethral discharge,
5.2. those STDs that are amenable to immediate diagnosis and treatment, and this
5.3. includes syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papillomhuman p, non-gonococcal urethritis, lymphogranuloma venereum andgranuloma inguinal and
5.4. evaluation and treatment of pelvic inflammatory disease

PROCEDURE

1. <u>Public Health Coordination</u>

1.1. IHHMG, in collaboration with the County STD and/or Communicable Disease liaisonwill accomplish the following:

1.1.1. Negotiate the Public Health Agreement.

1.1.2. Develop coordination policies and procedures.

1.1.3. Provide in-service training to staff and participating physicians.

1.1.4. Identify strategic opportunities to share resources that maximize positive healthoutcomes.

1.1.5. Communicate as specified in the Public Health Agreement with the local STDControl and/or Communicable Diseases Control liaison to facilitate data and information exchange.

1.1.6. Exchange provider listings, policy and program updates for internal and externaldistribution.

1.1.7. Work to resolve problems on a local level.

1.2. The Medical Director or Designee will meet as needed with the County Director of Communicable Disease Control to examine challenges and opportunities for improvingcollaboration.

2. Member Identification

2.1. Members in need of STD services may be identified through any of the following:

2.1.1. Community-based organizations

2.1.2. Initial health assessments

2.1.3. In-patient admissions (concurrent review)

2.1.4. Primary care physician (PCP) and Specialist

2.1.5. Case Management

2.1.6. Member Services

2.1.7. Emergency Room/Urgent Care utilization

2.1.8. Public Health Coordinator

2.1.9. Health Educator

2.1.10. Contracting

2.1.11. Authorization data

2.1.12. Claims data

2.1.13. PM 160 form

2.1.14. Encounter data

2.1.15. Marketing Representatives

2.1.16. Members

2.1.17. School-based clinics

2.1.18. Out of plan providers

3. Referral Process

3.1. Members may call the Medi-Cal, IHHMG or Health Plan Member Service Department forassistance with locating an out of plan provider in their area.

3.1.1. The Member Services Representative will inform the member that if follow-upservices are needed, it must be provided by an IHHMG participating physician.

3.1.2. No referral or prior authorization is required.

4. PCP Responsibilities

4.1. PCPs are responsible for case coordination for their assigned member, to submit the required reporting to the LHD and make referrals to medical specialists, as necessary.

4.2. PCPs assure appropriate documentation in the P/*PIC's* medical records.

4.3. PCPs provide follow up services to members who received diagnosis and treatment services from another provider, either in or out of plan.

5. Reporting Requirements

5.1. Each PCP is responsible for reporting to the LHD, within the specific timetable as foundin the Title 17, CCR, Section 2500, "Reporting to the Local Health Authority," the identification of the following STDs: syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranoloma, venereum andgranuloma inguinale. The information reportable to theLHD includes:

5.1.1. Member demographics: name, age, address, home phone, date of birth, gender,ethnicity and marital status;

5.1.2. Locating information: employer, work address and phone number;

5.1.3. Disease information: disease diagnosed, date on onset, symptoms, laboratoryresults and medication prescribed.

5.1.4. PCPs may refer members to STD services through LHD clinics or other out ofplan providers upon request of the member.

5.1.5. PCPs will provide and document preventive care health education provided

atthe time of routine exam, for all members with high-risk behaviors for STD infections.

6. If a health care provider reports a STD case, the report should include STD informationas to the specific causative agent, syphilis-specific laboratory finding and any complication of gonorrhea or chlamydia infections.

7. Reports of cases of communicable disease may be made by means of Confidential Morbidity Report Forms, which are available from the local health department. Providersmay request these forms from the local health department. Refer to the Medi-Cal Provider Manual for a list of reportable diseases from Title 17, CCR, Section 2500.

   7.1. In addition, any health care provider who has knowledge of an outbreak or undue prevalence of an infectious or parasitic disease or infestation (whether or not listed on the following page) must promptly report this information to the local health officer.A health care provider having knowledge of a case of an unusual disease not listed must also promptly report the facts to the local health officer.

8. <u>Protecting Patient/participant/client Confidentiality</u>

   8.1. In order to protect P/P/C confidentiality, members receiving services from IHHMG participating physicians are entitled to full consideration of privacy concerning the confidential treatment of all member communications and records.

   8.2. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. Written authorization from the member or the member's authorized legal representative should be obtained before medical recordsare released to anyone not directly concerned with the member's care, except as permitted, or as necessary in the administration of this health plan.

   8.3. When an out of plan provider or the LHD sees IHHMG members, the out of planprovider shall call the Medi-Cal, IHHMG, their Health Plan Member Services Department to verify eligibility and benefits.

      8.3.1. The Member Services representative provides the out of plan provider or theLHD with the name and telephone number of the member's PCP and claims submission instructions.

      8.3.2. The Medi-Cal, IHHMG, their Health Plan Member Service Department will also instruct the out of plan provider or LHD to send the report to the member'sPCP.

   8.4. If the out of plan provider requests case management services, the call will be transferred to the IHHMG Case Manager (if Delegated). The IHHMG or Health PlanCase Manager will arrange for the necessary follow-up care and coordinate with themember's PCP as necessary.

9. Tracking, Monitoring and Quality Oversight

9.1. The Claims Department reviews and analyzes claims data for STD services andadjudicates the claims accordingly.

9.2. The Authorization Coordinator prepares the communicable diseases reports to track and trend access to out of plan providers as requested. A report summary is submitted to the Quality Management Committee as requested.

9.3. The Plan's Quality Management Department monitors provider compliance with the requirement to report communicable diseases through regular medical record audits.

10. Claims and Grievance Issues

10.1. Member grievances regarding out of plan providers for STD services are referred tothe Health Plan for resolution.

10.2. Provider concerns and problems not related to claims are referred to IHHMGProvider Relations for resolution.

10.3. Member and Provider Appeals will be forwarded to the Health Plan for review and/orintervention.

10.4. Providers may submit appeals directly to the Health Plan or IHHMG for anyunresolved claims issue.

10.5. IHHMG will notify the Medical Director and the member's Health Plan of any appealssubmitted directly to IHHMG.

Reference(s)

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATIVE SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Storage of Immunizations for Children	
Policy Number(s): 10-013	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ IHP ☒ IHHMG ☒ IICT	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP, and Specialist shall follow the procedures set forth in this policy.

PURPOSE

To provide a provision of vaccines in accordance with the recommendations of The Advisory Committee on Immunization Practices (ACIP), FDA, and the current California Pediatric and Adult Immunization Programs, to all IHHMG members.

POLICY

NEW VACCINES FOR CHILDREN (VFC) VACCINE STORAGE GUIDELINES

Only 30% of the space provided by a typical combination refrigerator-freezer is acceptable forvaccine storage. Vaccines should **never** be stored as follows:

- On refrigerator shelves directly beneath air vents (generally the top-shelf)
- On refrigerator vegetable bins or deli crispers
- Within 2-3 inches of refrigerator wall surfaces
- Outside of their original packaging/boxes

Very high-volume providers receiving more than 10,000 vaccine doses per year will be required to store VFC supplied vaccines in a "pharmacy-grade or biologic grade freezer-less refrigerator" and "pharmacy-grade or biologic grade freezer only" unit. These units are designed for optimum cooling capacity and stable temperature control over the recommendedrange.

- High volume providers receiving between 2,000 and 10,000 vaccine doses per year willbe required to store VFC supplied vaccines in "refrigerator-only" units and "stand alone freezer" units.
- Medium volume providers receiving between 500 and 2,000 vaccine doses per year arestrongly encouraged to upgrade their vaccine storage units to a "freezer less refrigerator" and a "freezer-only" unit. *However, providers will be allowed to keep an existing household refrigerator/freezer combination storage unit as long as it meets* ***all*** *of the following specifications*:

1. Provides adequate useable vaccine storage space to store the largest anticipated vaccinesupply (e.g. during seasonal peaks, such as back-to school or flu season)

2. Maintains required vaccine storage temperatures without significant fluctuations year-round

3. Remains frost-free, and free of any visible water or coolant leaks. Cyclic defrost refrigerators (manual defrost freezer combined with a cyclic defrost of refrigerator compartment) are not acceptable. These units, with a visible cooling plate in the back of therefrigerator, often have visible frost formations in the main compartment of the refrigerator which require manual defrost.

4. Must be regularly maintained or serviced and without major required repairs within the pasttwo years

5. Doors seal tightly and close properly

6. Allows for vaccine storage at least 3 inches from internal walls and away from cold airvents.

7. Unit must be used exclusively for the storage of vaccines

    7.1. Low volume providers receiving less than 500 vaccine doses per year will be allowed tohave a combination storage unit if it meets all specifications listed above.

    7.2. Medium and Low volume providers with combination storage units that do not adhereto any one of the above listed specifications will be required to purchase separate "refrigerator-only" and "freezer-only" units.

    7.3. For those medium and low volume providers that continue the use of a combination storage unit, please be aware that you are responsible for ensuring that no vaccine is stored in vegetable bins, deli crispers, doors, or shelves located directly underneath airvents.

PROCEDURE

Reference(s)

http://www.dhcs.ca.gov/services/chdp/Documents/Letters/chdpin08F.pdf

Los Angeles County Immunization Program; California Department of Public Health; and Joint Commission MM 01.01.01

Attachments:
None

IMPERIAL MANAGEMENT
ADMINISTRATORS SERVICES

Policy and Procedure
Utilization Management Department□

Policy Title: Children's Preventive Services - CHDP	
Policy Number(s): 10-014	**Orig. Date:** 05/01/16
Effective Date: 05/01/16	**Revision(s) Date:**
MSC Committee Approval: **Date:** 03/25/21	**Department: UTILIZATION MANAGEMENT**
	VP/Director Approval: Josie Wong **Date:** 03/25/21
Applicable to: ☒ **IHP** ☒ **IHHMG** ☒ **IICT**	**SCOPE: UM**

SCOPE

Imperial Health Holdings Medical Group Utilization Management Staff, PCP, and Specialist shall follow the procedures set forth in this policy.

PURPOSE

The purpose of this policy is to provide a clear understanding of Children's' Preventative Services.

Children under age 21 with Medi-Cal are eligible to receive CHDP periodic health screenings and preventive health services.

POLICY

The Child Health and Disability Prevention (CHDP) is a preventive program that delivers periodic health assessments and services to low income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. Health assessments are provided by enrolled private physicians, local health departments, community clinics, managed care plans, and some local school districts.

PROCEDURE

Infants, Children and Teens with Medi-Cal are eligible for CHDP Services

Children under age 21 with Medi-Cal are eligible to receive CHDP periodic health screeningsand preventive health services. Children enrolled in Medi-Cal managed care

plans receive these services through their health care plan. Rescreening is necessary as children grow to make sure that no new problems develop and to provide immunizations and other preventivehealth services. Eligible children should receive one CHDP health assessment according to the periodic service schedule:

Birth -1 month 10 - 12 months 4 - 5 years

1 - 2 months 13 - 15 months 6 - 8 years

3 - 4 months 16 - 23 months 9 -12 years

5 - 6 months 2 years 13 - 16 years

Children under 21 years of age with Medi-Cal may receive preventive and restorative dental services at any time through Denti-Cal. For more information, Medi-Cal beneficiaries should call 1-800-322-6384.

Referrals to a participating dentist are recommended for children under 21 years of age beginning at one (1) year of age. CHDP health assessment providers are required to make a referral to a dentist annually beginning at three (3) years of age

Reference(s)

Health Periodicity pdf

Attachments:
None