MEDICAL REVIEW – RANCHO CUCAMONGA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

# INLAND EMPIRE HEALTH PLAN

# 2021

Contract Number: **04-35765**

Audit Period: October 1, 2019
Through
July 31, 2021

Report Issued: February 18, 2022

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# I. INTRODUCTION

Inland Empire Health Plan (Plan) was established on July 26, 1994 as the local initiative Medi-Cal Managed Care Health Plan in the Inland Empire. The Plan received its Knox-Keene license on July 22, 1996 and commenced operations on September 1, 1996 in Riverside and San Bernardino Counties.

The Plan provides managed care health services to Medi-Cal beneficiaries under the provision of Welfare and Institutions Code, section 14087.3. The Plan is a public entity, formed as a Joint Powers Agency, and a not-for-profit health plan. The Plan is headquartered in Rancho Cucamonga, California, created by Riverside and San Bernardino Counties as a two-plan Medi-Cal managed care model.

The Plan provides health care coverage to eligible members in San Bernardino and Riverside Counties as a mixed model Health Maintenance Organization. The Plan's contracted provider network consists of approximately eight Independent Physician Associations and 32 hospitals. The Plan also directly contracts with 1,129 Primary Care Physicians and 2,277 specialists.

As of July 31 2021, the Plan's enrollment for its Medi-Cal line of business was 1,383,946 and 31,119 for Cal MediConnect, with a total enrollment of 1,415,065 members.

# II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit of the Plan for the period of October 1, 2019 through July 31, 2021. The review was conducted from September 27, 2021 through October 8, 2021. The audit consisted of document review, verification studies, and interviews with Plan administrators, key personnel and one delegated entity.

An Exit Conference was held on January 28, 2022. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. The Plan did not submit any additional information. The results of the evaluation are reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM) Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management (QM), and Administrative and Organizational Capacity.

The prior DHCS medical audit report issued on January 8, 2020 (audit period October 1, 2018 through September 30, 2019) identified deficiencies incorporated in the Corrective Action Plan (CAP) dated April 28, 2020. This year's audit included review of documents to determine implementation and effectiveness of the Plan's CAP.

The summary of findings by category is as follows:

**Category 1 – Utilization Management**

The Plan is required to cover and ensure the provision of preventive services for members without prior authorization. The Plan inappropriately applied prior authorization requirements for preventive services.

The Plan is required to thoroughly document the periodic review and evaluation of their appeal system. The Plan did not document the periodic review conducted by its governing body, public policy body, and officer.

The Plan is required to identify the name of the decision maker within the appeal written notification letter. The Plan did not ensure the name of the decision maker was identified within the appeal written notification letter.

## Category 2 – Case Management and Coordination of Care

During the prior audit, the Plan did not notify members of the complete Continuity of Care (COC) transition process and did not ensure approval letters contained all required information. In response to the CAP, the Plan revised COC letters and implemented a new process to ensure inclusion of all required information.

Review of the Plan's case management and coordination of care, as well as review of the Plan's CAP response, yielded no findings.

## Category 3 – Access and Availability of Care

During the prior audit, the Plan did not have procedures to monitor waiting times for providers to answer and return members' telephone calls. In response to the CAP, the Plan revised telephone access standards to monitor wait times for providers to answer and return member's telephone calls. Review of the Plan's CAP response yielded no findings.

Plans and transportation brokers must use a DHCS approved Physician Certification Statement (PCS) form to determine the appropriate level of service for Medi-Cal members. The Plan did not ensure the required PCS forms were utilized for transportation services provided, nor did the Plan ensure PCS forms contained all required components.

Plan transportation providers are required to be enrolled in the Medi-Cal program. The Plan did not have a process in place to ensure its subcontracted transportation providers were enrolled in the Medi-Cal program.

## Category 4 – Member's Rights

During the prior audit, the Plan did not have procedures to timely notify members of the grievance status and estimated completion date when grievance resolutions extended beyond 30 calendar days. In response to the CAP, the Plan revised the Notice of Delay Letter and trained their staff. Review of the Plan's CAP response yielded no findings.

The Plan is required to maintain a grievance system that ensures timely review and resolution. The Plan did not ensure member grievances were completely resolved due to a lack of response from its network providers.

The Plan is required to take effective action to address needed improvements in the quality of care delivered by providers rendering services on its behalf. The Plan did not ensure corrective actions were enacted when addressing needed improvements to the quality of care delivered by its providers.

## Category 5 – Quality Management

The Plan is required to maintain a system that ensures accountability for delegated quality improvement activities including the continuous monitoring, evaluation, and approval of delegated functions. The Plan did not maintain adequate oversight of UM delegates. The Plan did not require delegates to report UM findings quarterly and did not monitor delegate reporting of underutilization.

## Category 6 – Administrative and Organizational Capacity

Review of the Plan’s identified overpayments and recoveries due to fraud, waste and abuse yielded no findings.

# III. SCOPE/AUDIT PROCEDURES

## SCOPE

The DHCS, Medical Review Branch conducted this audit of the Plan to ascertain medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the state's Two-Plan Contract.

## PROCEDURE

The review was conducted from September 27, 2021 through October 08, 2021 for the audit period October 1, 2019 through July 31, 2021. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies to determine the effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators, key personnel, and one delegated entity.

The following verification studies were conducted:

### Category 1 – Utilization Management

Prior Authorization Requests: 30 medical prior authorization requests and ten pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Appeals Process: 35 Medical appeals and two pharmacy appeals were reviewed for appropriate and timely adjudication.

### Category 2 – Case Management and Coordination of Care

Behavioral Health Treatment: Ten member files were reviewed to confirm coordination of care and fulfillment of behavioral health requirements.

COC: Five member files were reviewed for completeness and compliance with the required timeframes.

### Category 3 – Access and Availability of Care

Non-Emergency Medical Transportation and Non-Medical Transportation (NEMT/NMT): 23 NEMT and eight NMT records were reviewed to confirm compliance with transportation requirements and appropriateness of service provided.

Delegated (NEMT/NMT) Transportation: 11 NEMT and eight NMT records were reviewed to confirm compliance with transportation requirements and appropriateness of service provided.

**Category 4 – Member's Rights**

Grievance Procedures: 70 grievances (including 21 quality of care, 31 quality of service, eight exempt, and ten expedited) and 30 inquiries were reviewed for timely resolution, classification, appropriate response to complainant, and submission to appropriate level for review.

**Category 5 – Quality Management**

Quality Improvement System: Five potential quality incident files were reviewed for proper decision-making and effective actions taken to address needed quality improvements.

**Category 6 – Administrative and Organizational Capacity**

Identified Overpayments: Five cases were reviewed to confirm reporting of Plan identified overpayments and recoveries due to fraud, waste, and abuse to DHCS.

A description of the findings for each category is contained in the following report.

## ❖ COMPLIANCE AUDIT FINDINGS ❖

**PLAN: Inland Empire Health Plan**

**AUDIT PERIOD: October 1, 2019 through July 31, 2021**
**DATE OF AUDIT: September 27, 2021 through October 8, 2021**

## CATEGORY 1 - UTILIZATION MANAGEMENT

| 1.2 | PRIOR AUTHORIZATION REVIEW REQUIREMENTS |
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### 1.2.1 Prior Authorization Requirements Exemption for Preventive Services

Prior authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and human immunodeficiency virus testing. *(Contract, Exhibit A, Attachment 5(2)(F))*

Plan Policy *MC_14D-Pre-Service Referral Authorization Process (revision date: 1/01/2021)* states in part that prior authorization is not required for preventive services.

**Finding:** The Plan applied prior authorizations to preventive services.

During the audit period, the Plan required the processing of prior authorizations for preventive services such as lung cancer and osteoporosis screenings. The Plan did not implement its policy, MC_14D-Pre-Service Referral Authorization Process, since the Plan also maintained an automated process requiring prior authorizations for preventive services. The Plan explained that a lack of effective oversight resulted in noncompliance with Contract requirements for the provision of preventive services.

When prior authorization is required for preventive health services, it can create a barrier for members in obtaining necessary screenings which can potentially delay appropriate medical diagnosis and treatment.

**Recommendation:** Revise and implement policies and procedures to ensure prior authorization requirements are not a prerequisite for preventive services.

| ❖ COMPLIANCE AUDIT FINDINGS ❖ |
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| **PLAN: Inland Empire Health Plan** |
| **AUDIT PERIOD: October 1, 2019 through July 31, 2021**<br>**DATE OF AUDIT: September 27, 2021 through October 8, 2021** |

| 1.3 | PRIOR AUTHORIZATION APPEAL REVIEW REQUIREMENTS |
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### 1.3.1 Appeals System Oversight

Contractor shall have in place a system in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph F.13 and 42 CFR 438.402-424. Contractor shall follow Appeal requirements, and use all notice templates included in APL 17-006. (*Contract, Exhibit A, Attachment 14, section 1)*

The written record of appeals shall be reviewed periodically by the governing body of the Plan, the public policy body created pursuant to section 1300.69, and by an officer of the Plan or their designee. The review shall be thoroughly documented. (*CCR, Title 28, section 1300.68 (b)(5)*)

The written record of appeals shall be reviewed periodically by the governing body of the Managed Care Plan (MCP), the public policy body and by an officer of the MCP or designee. The review shall be thoroughly documented. *(APL 17-006)*

**Finding:** The Plan did not document the periodic review and evaluation of their appeals written log. The Plan did not have documentation of the review conducted by the governing body, public policy body and officer, or designee.

Review of the Plan's governing body and Public Policy Participation Committee meeting minutes did not contain review of the written log of appeals during the audit period. The Plan did not adequately document their review that would demonstrate the quality interventions implemented.

Without adequate documentation of the Plan's oversight and review of appeal logs, the governing board will lack the ability to understand the members' actual issues which can lead to missed quality improvement opportunities.

**Recommendation:** Develop and implement procedures to ensure thorough documentation of periodic appeals review by the governing body, public policy body, and officer or designee.

### 1.3.2 Decision Maker and Written Notification Letters

Contractor shall have a system in place that follows appeal requirements and use all notice templates included in APL 17-006. Ensure that the person making the final decision has neither participated in any prior decisions related to the appeal, nor is a subordinate of someone who has participated in a prior decision. *(Contract, Attachment 14, section 1 (D))*

MCPs shall comply with all other existing state laws and regulations in determining whether to approve, modify, or deny requests by providers prospectively, concurrently, or retrospectively. For decisions based in whole or in part on medical necessity, the written notice of action letter shall contain the name and direct telephone number or extension of the decision maker. *(APL 17-006)*

Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification.
*(CA Health & Safety Code § 1367.01 (h) 4)*

Plan Policy *MC_16A Member Grievance and Appeals Resolution Process (revision date: 1/01/2021)* and *MC_16A2 Grievance resolution Process-Member Urgent Medical Grievances (revision date: 1/01/2020)* states in part that the Plan provides members with clear and concise written responses to appeals which includes the reason for response, and explanations regarding denials and modifications. In addition, the policies also state that the Plan provides members with copies of the case, including medical records and information used to make a decision.

**Finding:** The Plan did not identify the name of the decision maker within the written appeal notification letter.

The Plan's written notification letters did not meet the requirement to identify the name of the decision maker for the proposed appeals. The verification study review revealed the following:

- 37 appeal resolution letters did not have the name of the health care professional responsible for the decision.

- Four downgraded expedited appeal request notification letters did not have the name of the health care professional responsible for the decision.

During the interview, the Plan stated the decision maker's name was not included within the appeal written notification letters due to their interpretation of the requirement, and as a result the resolution letters identified the decision maker's specialty of practice but did not identify the individual's name. However, the Plan's policies did not incorporate a process to include the name of the health care professional responsible for the grievance or appeal decision.

The name of the health care professional responsible for the appeal decision allows members to quickly locate the individual and provides the opportunity to facilitate the exchange of additional information to possibly reverse an adverse decision.

Without the name of the decision maker contained within written notification letters, the member may have further delays in receiving medically necessary services.

**Recommendation**: Revise policy and implement procedures to include the name of the health care professional responsible for making the appeal decision within written notification letters.

| ❖ COMPLIANCE AUDIT FINDINGS ❖ |
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| **PLAN: Inland Empire Health Plan** |
| **AUDIT PERIOD: October 1, 2019 through July 31, 2021**<br>**DATE OF AUDIT: September 27, 2021 through October 8, 2021** |

| CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE |
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| 3.8 | NON-EMERGENCY MEDICAL TRANSPORTATION AND NON-MEDICAL TRANSPORTATION |
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### 3.8.1 Physician Certification Statement (PCS) form

All Policy Letters and All Plan Letters (APL) issued by DHCS subsequent to the effective date and during the term of this Contract shall provide clarification of Plan's obligations pursuant to this Contract, may include instructions to the Plan regarding implementation of mandated obligations pursuant to changes in state or federal statues or regulations, or pursuant to judicial interpretation. (Contract, Exhibit E, Attachment 2, section 1, (D)(1))

According to the APL 17-010, NEMT services are a covered Medi-Cal benefit when members need to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist, mental health or substance use disorder provider. Plans and transportation brokers must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. In order to ensure consistency amongst all Plans, all NEMT PCS forms must include, at a minimum, the following: function limitations justification, dates of service needed, modes of transportation needed, and certification statement.

Plan Policy *MC_09C Non-Emergency Medical and NMT Service (revision date: 1/01/2021)* mirrors APL 17-010 stating in part, NEMT services are a covered Medi-Cal benefit when prescribed in writing by an approved treating provider. The policy also states that treating providers must complete and submit the PCS form to the Plan prior to the provision of transportation services.

**Finding:** The Plan did not ensure the required PCS forms were utilized for transportation services provided, nor did the Plan ensure PCS forms contained all required components.

The verification study revealed 18 of 23 NEMT trips did not contain the required PCS forms. The verification study also revealed that the provider's electronic PCS form was not DHCS approved and did not include the required dates of service.

According to APL 17-010, plans and transportation brokers must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. According to the interview, non-acquisition of the PCS form did not preclude members from receiving transportation services. As a result, members were transported without

the necessary DHCS approved PCS form. The Plan also explained that an electronic PCS form is maintained within the portal for ease of provider use. The Plan however, did not have procedures in place to ensure its electronic PCS form was DHCS approved and contained all required components.

Without obtaining a DHCS approved form that contains all required components, the Plan cannot ensure Medi-Cal members receive the necessary and appropriate level of transportation services which can potentially result in patient harm.

**Recommendation:** Revise and implement policies and procedures to ensure DHCS approved PCS forms contain all required components and are obtained prior to providing transportation services.

### 3.8.2 Enrollment of subcontracted transportation providers

The Plan shall ensure subcontractor's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care program. (*Contract, Exhibit A, Attachment 6, section 14, (B) (21)*

The Plan is required to ensure all network providers are enrolled in the Medi-Cal program. MCP will remain contractually responsible for the completeness and accuracy of the screening and enrollment activities. To ensure that the subcontractor meets both the MCP's and DHCS' standards, the delegating MCP must evaluate the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities. The MCP must continuously monitor, evaluate, and approve the subcontracted functions. (APL 19-004)

Plan Policy *Pro_Con 08 Processing Agreement for perspective direct Providers (revision date: 1/01/2021)*, states in part that network providers are required to enroll in the Medi-Cal program.

**Finding:** The Plan did not have a process in place to ensure its subcontracted transportation providers were enrolled in the Medi-Cal program.

The Plan utilizes a subcontracted vendor to assist in providing ground transportation services to members. According to the Plan's agreement, the transportation subcontractor is required to comply with all applicable state, federal and contractual requirements.

Although the Plan stated during the interview that weekly discussions were conducted with their transportation vendor to address operation and grievance issues, this weekly forum did not address Medi-Cal enrollment for transportation providers. The Plan did not have a process in place to ensure its subcontracted transportation vendor complied with Medi-Cal enrollment requirements and as a result, the verification study revealed eight subcontracted transportation providers were not enrolled in the Medi-Cal program while providing transportation services to Medi-Cal beneficiaries.

Without adequate oversight, the Plan cannot ensure its subcontracted transportation vendor is in compliance with Medi-Cal enrollment requirements which can potentially result in members receiving unsafe transportation services. In addition, lack of subcontractor oversight can result in missed quality improvement opportunities.

**Recommendation:** Revise policy and implement a process to ensure NEMT and NMT subcontractors' compliance with Medi-Cal enrollment requirements.

| ❖ COMPLIANCE AUDIT FINDINGS ❖ |
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| **PLAN: Inland Empire Health Plan** |
| **AUDIT PERIOD: October 1, 2019 through July 31, 2021**<br>**DATE OF AUDIT: September 27, 2021 through October 8, 2021** |

| CATEGORY 4 – MEMBER'S RIGHTS |
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| 4.1 | GRIEVANCE SYSTEM |
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### 4.1.1 Grievance Resolution

The Plan shall provide a resolution notice to the member as quickly as the member's health condition requires, within 30 calendar days from the date the Plan receives the grievance. (*Contract, Exhibit A, Attachment 14, (1)(B))*

The Plan's grievance system shall provide for a prompt review of grievances by the management or supervisory staff responsible for the services or operations which are the subject of the grievance. Resolved means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance*. (CCR, Title 28, §1300.68(a)(4)(d)(2))*

Plan Policy *MED_GRV 2 – Member Grievance Resolution System – Standard and Expedited (revision date: 1/01/2020)* states that providers are required to respond back to the Plan within 14 days as part of the grievance investigation process and to appropriately determine the outcome prior to submitting resolution letters to members.

**Finding:** The Plan did not ensure member grievances were completely resolved due to a lack of response from its network providers.

The Plan is required to take actions to investigate and resolve grievances within 30 days. The Plan's Grievance and Appeal Department utilizes a Grievance Summary Form (GSF) which is a correspondence sent to providers to assist in the resolution of member complaints. As part of the Plan's grievance investigation process, providers are sent the GSF form and required to complete and return the form timely.

The verification study revealed 21 grievances that were not completely resolved due to a lack of response from providers. The Plan did not ensure its network providers complied with timely documentation request when resolving member grievances.

Incomplete resolution of member grievances could result in the delay of members pursuing appropriate health care delivery services.

**Recommendation:** Develop and implement a process to ensure that the Plan resolves all member grievances within the required timeframes.

### 4.1.2 Escalation of CAP Process

The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting regardless of the number of contracting and subcontracting layers between the Plan and the providers. (*Contract, Exhibit A, Attachment 4, section (1))*

Plan Policy *MC_25A1 Delegation Oversight (revision date: 1/1/2021)* explains that when providers are unable to correct or comply with the CAP within specified timeframe, the Plan will take the necessary steps up to and including revocation of delegation in whole and in part.

**Finding:** The Plan did not ensure corrective actions were enacted when addressing needed improvements to the quality of care delivered by its providers.

The Plan designates the oversight of its providers to the Delegation Oversight Committee. The oversight and performance responsibilities include detection and remediation of any provider performance deficiencies through the issuance of CAPs and other disciplinary actions.

A verification study revealed 21 standard grievances were not completely resolved due to a lack of response from providers during the investigation process. The Plan identified the lack of provider response to grievance inquiries but did not take effective action in addressing the needed improvements to the quality of care delivered by its providers.

In addition, the Plan did not ensure continuous monitoring nor evaluation of non-compliant providers as there was no escalation of disciplinary actions when CAPs were enacted but did not improve provider performance.

Without adequate oversight or follow-up of non-compliant providers, the Plan may lack the ability to take effective action to address any necessary improvements in the quality of care and service delivered to members.

**Recommendation:** Develop and implement procedures and implement effective corrective action to ensure adequate oversight and follow-up of non-compliant providers.

| ❖ COMPLIANCE AUDIT FINDINGS ❖ |
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| **PLAN: Inland Empire Health Plan** |
| **AUDIT PERIOD: October 1, 2019 through July 31, 2021**<br>**DATE OF AUDIT: September 27, 2021 through October 8, 2021** |

| CATEGORY 5 – QUALITY MANAGEMENT |
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| 5.1 | QUALITY IMPROVEMENT SYSTEM |
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### 5.1.1 Quality Improvements

The Plan shall maintain a system to ensure accountability for delegated quality improvement activities that at a minimum, includes the continuous monitoring, evaluation, and approval of the delegated functions. (Contract, Exhibit A, Attachment 4(6)(B)(3))

The Plan shall require subcontractors to report findings and actions taken as a result of quality improvement activities at least quarterly. (Contract, Exhibit A, Attachment 4(6)(A)(3))

Contractor shall include within the UM program mechanisms to detect both under and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member utilization patterns shall be reported to DHCS upon request. (Contract, Exhibit A, Attachment 5 (4))

Plan policy *PRO_DEL 06 Delegation Oversight Committee (revision date: 01/01/2021)* states in part the Plan's Delegation Oversight Committee audits and monitors on a monthly basis, the operational activities of contracted Independent Physician Associations and other delegate activities such as, UM, Grievances, and Appeals.

Plan policy *MC_25 D3 QM - CAP Requirements (revision date: 1/01/2020)* states in part that QM monitoring activities include monthly, quarterly, semi-annual, and annual report submission.

**Finding:** The Plan did not maintain adequate oversight of UM delegates. The Plan did not require delegates to report UM findings quarterly and did not monitor delegate reporting of underutilization.

The Plan did not require their delegates to report UM findings quarterly as required by its policy and the Contract. The Plan stated that its delegates were only required to submit UM Program reports semi-annually and annually, in which the Plan provides review and recommendations for improvement.

Additionally, the Plan did not adequately monitor delegate reporting of underutilization. Review of nine Independent Physician Associations Industry Collaborative Effort reports submitted to the Plan for review did not have underutilization data.

Receipt and review of delegated UM reports on a semi-annual basis instead of a quarterly basis may delay initiation of effective action necessary to address any needed improvements in the quality of care delivered by Plan delegates. Without adequately monitoring delegate reporting of underutilization, the Plan cannot ensure that medically necessary services are appropriately utilized which could negatively impact member's overall health.

**Recommendation:** Revise and implement policies and procedures to ensure adequate oversight of UM delegates, early identification of issues, and timely initiation of interventions through quality improvement activities.

MEDICAL REVIEW BRANCH – RANCHO CUCAMONGA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

# INLAND EMPIRE HEALTH PLAN
## STATE SUPPORTED SERVICES AUDIT REPORT

## 2021

Contract Number: 03-75797

Audit Period: October 1, 2019
Through
July 31, 2021

Report Issued: February 18, 2022

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# I. INTRODUCTION

This report represents the recent audit of Inland Empire Health Plan (Plan) State Supported Services Contract No. 03-75797. The State Supported Services Contract covers contracted abortion services with the Plan.

The review was conducted from September 27, 2021 through October 08, 2021 for the audit period October 1, 2019 through July 31, 2021. The audit consisted of document review of materials supplied by the Plan, verification study, and interviews.

An Exit Conference with the Plan was held on January 28, 2022. There were no deficiencies found for the review period on the Plan's State Supported Services.

Ten supported services claims were reviewed for appropriate and timely adjudication.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

**PLAN:** Inland Empire Health Plan

**AUDIT PERIOD: October 1, 2019 through July 31, 2021**
**DATE OF AUDIT: September 27, 2021 through October 8, 2021**

## STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

The Plan agrees to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Coding System Codes 59840 through 59857 and Health Care Finance Administration Common Procedure Coding System Codes X1516, X1518, X7724, X7726, and Z0336. These codes are subject to change upon the Department of Health Care Services implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code sets provisions. *(Contract, Exhibit A, (1))*

Plan Policy *OPS/CLM P-13: State Supported Services Abortion* states, abortion is covered by the Medi-Cal program as a physician service. Members have the right to access abortion services through a contracted or non-contracted qualified provider and services are generally rendered on an outpatient basis. Additionally, abortion services and related supplies do not require prior authorization. However, if the abortion services require inpatient hospitalization, the inpatient facility services (only) require authorization.

Review of the Plan's State Supported Services claims processing system and abortion services billing procedure codes yielded no findings for this year's audit.

**RECOMMENDATION:**

None