Policy:	MA.6042
Title:	**Integrated Organization Determinations**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/ Michael Hunn 12/20/2024*
Effective Date:	04/01/2017
Revised Date:	12/01/2024
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the standards and timeframes by which CalOptima Health, or a Health Network shall make Integrated Organization Determinations (IOD) for a Member.

II. POLICY

A. CalOptima Health or a Health Network shall consider both Medicare and Medi-Cal coverage criteria when making an IOD decision and issue an approval or denial of coverage of services, in whole, or in part.

B. CalOptima Health or a Health Network shall make a standard or expedited IOD in accordance with the provisions of this Policy.

C. An adverse IOD shall occur when CalOptima Health or a Health Network denies the coverage or payment of services, in whole or in part.

D. CalOptima Health shall delegate IOD functions to its contracted Health Networks pursuant to the terms and conditions in this Policy and provide oversight in accordance with CalOptima Health Policy GG.1541: Utilization Management Delegation.

E. CalOptima Health or a Health Network shall notify a Member of an IOD regarding the approval or denial for coverage of services in accordance with the provisions of this Policy, and for the payment of services, in accordance with CalOptima Health Policy MA.3101: Claims Processing.

F. CalOptima Health or a Health Network shall notify a Member of a standard IOD decision with respect to the following:

1. A request for coverage of services that does not meet the criteria for an expedited Integrated Organization Determination as outlined in Section II.H. of this Policy.

2. CalOptima Health's or a Health Network's denial to cover services, in whole, or in part, including the type or level of services that the Member believes should be furnished, or arranged, by CalOptima Health or the Health Network.

3. Discontinuation or reduction of services if the Member believes that continuation of the services is Medically Necessary; and

4. CalOptima Health's or a Health Network's failure to approve, furnish, or arrange for a Member's services in a timely manner.

G. The request for a standard IOD shall be made as set forth in CalOptima Health Policy GG.1508: Authorization and Processing of Referrals, and may be made at any time by the following:

1. A Member or the Member's Authorized Representative;

2. Any Provider that furnishes, or intends to furnish, services to a Member; or

3. The legal representative of a deceased Member's estate.

H. A Member, the Member's Authorized Representative, or the Member's Provider (regardless of whether the Provider is affiliated with CalOptima Health), or staff of said Provider's office acting on said physician's behalf, may request an expedited IOD with respect to the following:

1. CalOptima Health's or a Health Network's denial to cover services, in whole, or in part, including the type or level of services that the Member believes should be furnished, or arranged, by CalOptima Health or a Health Network; and

2. Discontinuation or reduction of services if the Member believes that continuation of the services is Medically Necessary.

I. CalOptima Health or a Health Network shall provide an expedited IOD if it determines, or the Member's Provider indicates, that applying the standard IOD time frame could jeopardize the life or health of the Member, or the Member's ability to regain maximum function.

J. CalOptima Health or Health Network shall make a standard IOD as expeditiously as the Member's health condition requires, but no later than fourteen (14) calendar days from the receipt of the request for a standard IOD.

K. CalOptima Health or a Health Network shall make an expedited IOD no later than seventy-two (72) hours from the receipt of the request from the Member, a Member's Authorized Representative, or the Member's Provider has requested an expedited IOD as set forth in this policy.

L. CalOptima Health or a Health Network shall notify a Member of an adverse IOD and provide the "State Hearing Rights" attachment as applicable with respect to the following:

1. CalOptima Health's or a Health Network's denial to cover services, in whole or in part, including the type or level of services that the Member believes should be furnished, or arranged, by CalOptima Health or a Health Network;

2. Discontinuation or reduction of services if the Member believes that continuation of the services is Medically Necessary; or

3. CalOptima Health's or a Health Network's failure to approve, furnish, or arrange for a Member's services in a timely manner.

M. CalOptima Health or a Health Network shall notify the requesting parties of dismissal of IOD request, in whole or in part, under any of the following circumstances:

1. The individual or entity making the request is not permitted to request an IOD. This means the requesting entity is NOT:

    a. A Member or the Member's Authorized Representative;

    b. Any Provider that furnishes, or intends to furnish, services to a Member; or

    c. The legal representative of a deceased Member's estate.

2. The individual or entity making the request failed to make a valid request for an IOD or coverage determination.

3. The Member dies while the request is pending, and both of the following apply:

    a. The Member's surviving spouse or estate has no remaining financial interest in the case; and

    b. No other individual or entity with a financial interest in the case wishes to pursue the IOD.

N. If CalOptima Health or a Health Network does not have sufficient information to make the IOD, it shall make reasonable and diligent efforts to obtain all necessary information, including Medical Records and other pertinent documentation, from the Member's Provider.

1. CalOptima Health may employ the following outreach methods, as appropriate, to obtain the missing information:

    a. Telephone;

    b. Fax;

    c. Email; and/or

    d. Standard or overnight mail with a certified return receipt.

O. CalOptima Health or a Health Network shall notify a Member of a standard, expedited, or adverse IOD within their respective designated time frames outlined in Section III A-C of this Policy, unless CalOptima Health or a Health Network extends the IOD time frame in accordance with this Policy.

P. CalOptima Health shall internally audit and monitor the IOD standards and time frames outlined herein and be subject to corrective and disciplinary actions if it fails to adhere to said standards, in accordance with CalOptima Health Policy HH.4002: CalOptima Health Internal Oversight.

Q. CalOptima Health shall audit and monitor the IOD standards and time frames of the delegated Health Networks outlined herein in accordance with CalOptima Health Policies GG.1541: Utilization Management Delegation and GG.1619: Delegation Oversight. If a Health Network fails to adhere to the standards and time frames outlined herein, CalOptima Health may impose a corrective action plan (CAP) and/or sanction in accordance with CalOptima Health Policies HH.2005: Corrective Action Plan and HH.2002: Sanctions.

R. If a Member disagrees with the IOD, the Member may request an Appeal in accordance with CalOptima Health Policies. MA.9004: Expedited Pre-Service Integrated Appeal and MA.9015 Standard Integrated Appeals.

S. Member notification shall comply with requirements for written materials pursuant to CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

T. When the party that initiated the request voluntarily decides that a decision on their request is no longer needed, the party may communicate this desire to CalOptima Health or the Members Health Network. A Member, the Member's Authorized Representative, or the Member's Provider (regardless of whether the Provider is affiliated with CalOptima Health), or staff of said Provider's office acting on said physician's behalf, may request withdrawal of their request for an IOD or coverage at any time before the decision is issued.

III. PROCEDURE

A. Standard IOD

1. CalOptima Health or a Health Network shall make a standard IOD as expeditiously as a Member's health condition requires, no later than fourteen (14) calendar days from receipt of request.

2. CalOptima Health or a Health Network may not extend the IOD time frames.

3. CalOptima Health or the Health Network will provide a Member with advance notice at least (10) days in advance of the effective date of the action, in cases where a previously approved item or service is being reduced, suspended, or terminated, in accordance with 42 CFR § 422.631 (d)(2)(i)(A).

B. Expedited Integrated Organization Determination

1. A Member, the Member's Authorized Representative, or the Member's Provider (regardless of whether the Provider is affiliated with CalOptima Health), shall request an expedited IOD by submitting a verbal or written request to CalOptima Health, or the Member's Health Network responsible for making the IOD.

   a. A Member's Provider may provide verbal, or written, support for the request for an expedited IOD.

   b. CalOptima Health, or a Health Network, shall document all verbal requests for an expedited IOD, in writing, and maintain the documentation in the Member's case file.

2. If CalOptima Health or a Health Network approves the request for an expedited IOD, CalOptima Health or a Health Network shall provide the Member and the Member's Provider with the IOD, whether adverse, or favorable, as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours from when receiving the request for an expedited IOD.

   a. If CalOptima Health or a Health Network requires additional information to make the expedited IOD, CalOptima Health, or a Health Network, shall outreach to the Provider immediately upon receipt of the request.

b. If CalOptima Health or a Health Network needs medical information from a non-contracted Provider, CalOptima Health or a Health Network shall request the necessary information from the non-contracted Provider within twenty-four (24) hours after receipt of the request for an expedited IOD.

3. CalOptima Health or a Health Network may not extend the time frame for an expedited IOD.

4. If CalOptima Health or a Health Network determines the request for an expedited IOD, does not meet expedited criteria CalOptima Health or a Health Network shall take the following actions:

   a. Automatically transfer the request to the standard IOD time frame and process the IOD in accordance with Section III.A. of this Policy. The (14) day period begins with the day the request was received for an expedited determination.

   b. Provide the Member verbal notice of the denial for an expedited IOD within twenty-four (24) hours and subsequently deliver a written confirmation of the denial within three (3) calendar days of the verbal notice. The written confirmation of the denial shall:

      i. Explain that CalOptima Health or a Health Network shall automatically transfer and process the request using the fourteen (14) calendar day timeframe for standard IOD;

      ii. Inform the Member of the right to file an expedited Grievance and explain the Grievance process and time frames, as set forth in CalOptima Health Policies MA.9002: Enrollee Grievance Process, MA.9004 Expedited Pre-Service Integrated Appeals and MA.9015: Standard Integrated Appeals if the Member disagrees with CalOptima Health's or the Health Network's decision not to expedite the IOD; and

      iii. Notify the Member of the right to resubmit a request for an expedited IOD with a Provider's support.

5. CalOptima Health or a Health Network shall state the specific reason(s) for the IOD in understandable language and in an easy-to-read format for the Member.

   a. If CalOptima Health or a Health Network verbally notifies a Member of an adverse expedited IOD, CalOptima Health or a Health Network shall mail the Member written confirmation of the IOD within three (3) calendar days after providing the verbal notice.

   b. CalOptima Health or a Health Network shall include the following information in the Integrated Organization Determination, if the Integrated Organization Determination is not completely favorable to the Member:

      i. Inform the Member of the Member's right to Appeal;

      ii. Describe the standard Appeal process, as set forth in CalOptima Health Policy, MA.9015: Standard Integrated Appeals and the Member's right to request, and the conditions for obtaining, an expedited Appeal, in accordance with CalOptima Health Policy MA.9004: Expedited Pre-Service Appeal; and

C. Adverse IOD

1. CalOptima Health's or a Health Network's failure to provide a Member with timely notice of an Organization Determination constitutes an adverse IOD and the Member may Appeal the IOD

in accordance with CalOptima Health Policies, MA.9004: Expedited Pre-Service Integrated Appeal and MA.9015: Standard Integrated Appeals.

2. CalOptima Health or a Health Network shall utilize the Coverage Decision Letter form to notify a Member of an adverse IOD. If the Member has an Authorized Representative, CalOptima Health, or a Health Network, shall send a copy of the Coverage Decision Letter to the Member's Authorized Representative.

3. CalOptima Health or a Health Network shall utilize the Notice of Dismissal of Coverage Request form to notify a Member of a dismissal of IOD or coverage determination. If the Member has an Authorized Representative, CalOptima Health or a Health Network shall send a copy of the Notice of Dismissal to the Member's Authorized Representative.

4. CalOptima Health or a Health Network shall provide the following information on the Coverage Letter Determination or Notice of Dismissal in a readable and understandable format:

    a. The specific reasons for the denial or dismissal, taking into account the Member's medical condition, disabilities, and special language requirements, if any;

    b. Inform the Member of his or her right to request a standard Appeal in accordance with CalOptima Health Policy MA.9015: Standard Integrated Appeals or an expedited Appeal in accordance with CalOptima Health Policy MA.9004: Expedited Pre-Service Appeal , and to appoint a representative to file the Appeal on the Member's behalf, if desired;

    c. Describe the standard and expedited Appeal processes, time frames, and other elements; and

    d. Inform the Member of his or her right to submit additional evidence in writing, or in person.

5. CalOptima Health or a Health Network shall notify a Member, in writing, of an adverse standard IOD as expeditiously as the Member's health condition requires, but no later than fourteen (14) calendar days from receiving the standard request for services,

    a. If CalOptima Health or a Health Network verbally notifies a Member of an adverse IOD, CalOptima Health or a Health Network shall mail the Member a written confirmation of the IOD within fourteen (14) calendar days after the verbal notification.

6. CalOptima Health or a Health Network shall notify a Member, in writing, or an adverse expedited IOD as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours from receiving the expedited request for services.

    a. If CalOptima Health or a Health Network verbally notifies a Member of an adverse expedited IOD, CalOptima Health or a Health Network shall mail the Member a written confirmation of the IOD within three (3) calendar days after the verbal notification.

D. CalOptima Health or a Health Network must provide notice to the individual requesting the dismissal, Member, and Provider the determination to dismiss in writing via mail or another electronic format. The notice shall include:

1. The reason for the dismissal;

2. The right to request CalOptima Health or the Health Network vacate the dismissal action; and

3. The right to request a reconsideration of the dismissal.

E. CalOptima Health shall document all outreach attempts to contracted and non-contracted Providers, including, but not limited to, the following:

1. Date/time of the postmark;

2. Timestamp on emails/faxes;

3. Date/time of telephone call(s);

4. Detailed description of the information requested;

5. Contact information provided to assist Provider with completing the request; and

6. Name and position of individual conducting the outreach.

IV. ATTACHMENT(S)

A. Coverage Decision Letter H5433_20UM001_C
B. Services Requested Do Not Meet Expedited Criteria Notice (OneCare) H5433_UM1004
C. Notice of Authorization of Services H8016_UM17_5_ (OneCare)
D. Notice of Dismissal H5433_22UM001_C

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Dual Eligible Special Needs Plans (D-SNPs)
C. Medicare Managed Care Manual
D. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
E. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
F. CalOptima Health Policy GG.1541: Utilization Management Delegation
G. CalOptima Health Policy GG.1619: Delegation Oversight
H. CalOptima Health Policy HH.2002: Sanctions
I. CalOptima Health Policy HH.2005: Corrective Action Plan
J. CalOptima Health Policy HH.4002: CalOptima Health Internal Oversight
K. CalOptima Health Policy MA.3101: Claims Processing
L. CalOptima Health Policy MA.9002: Enrollee Grievance Process
M. CalOptima Health Policy MA.9004: Expedited Pre-Service Integrated Appeal
N. CalOptima Health Policy MA.9015: Standard Integrated Appeals
O. "Updated Guidance on Outreach for Information to Support Coverage Decisions" Centers for Medicare and Medicaid Services, Issued 2/22/2017
P. Plain Writing Act of 2010
Q. Title 42, Code of Federal Regulations (C.F.R.), §422.566, 422.568, 422.570(a-e), 422.572(b)(1), (c) and (e), 422.578, and 422.590(e)(1)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2017	MA.6042	Organization Determinations	OneCare OneCare Connect
Revised	01/01/2019	MA.6042	Organization Determinations	OneCare OneCare Connect
Revised	10/01/2020	MA.6042	Organization Determinations	OneCare OneCare Connect
Revised	11/01/2021	MA.6042	Organization Determinations	OneCare OneCare Connect
Revised	05/01/2022	MA.6042	Organization Determinations	OneCare OneCare Connect
Revised	12/31/2022	MA.6042	Integrated Organization Determinations	OneCare
Revised	12/31/2023	MA.6042	Integrated Organization Determinations	OneCare
Revised	12/01/2024	MA.6042	Integrated Organization Determinations	OneCare

IX. GLOSSARY

Term	Definition
Appeal	As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.
Authorized Representative/Legal Representative	An individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, as the law of the State in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request; e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity (see §40.2.1). Form CMS-1696 may not be used to appoint an authorized representative for the purposes of enrollment and disenrollment. This form is solely for use in the claims adjudication or claim appeals process and does not provide broad legal authority to make another individual's healthcare decisions.
Grievance	An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Integrated Appeal	Any of the procedures that deal with, or result from, adverse integrated organization determinations by CalOptima Health on the health care services the Member believes they are entitled to receive, including a delay in providing, arranging for, or approving the health care services such that a delay would adversely affect the health of the Member, or on any amounts the Member must pay for a service.
Integrated Grievance	A dispute or complaint that would be defined and covered, for grievances filed by an enrollee in non-applicable integrated plans, under § 422.564 or §§ 438.400 through 438.416 of this chapter. Integrated grievances do not include appeals procedures and QIO complaints, as described in § 422.564(b) and (c). An integrated grievance made by an enrollee in an applicable integrated plan is subject to the integrated grievance procedures in §§ 422.629 and 422.630. Integrated grievances do not include grievances related to Part D benefits.

Term	Definition
Integrated Organization Determination (IOD)	For the purpose of this policy an Integrated Organization Determination (IOD) is any determination made by CalOptima Health's with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider other than OneCare that the Member believes a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by OneCare. 3. Refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by CalOptima Health; 4. Discontinuation of a service if the Member believes that continuation of the service is Medically Necessary; and 5. Failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
Medical Record	A Medical Record, health record, or medical chart in general is systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Medically Necessary/Medical Necessity	Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	A beneficiary enrolled in a CalOptima Health Program.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.
Provider	Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.