12. COORDINATION OF CARE

A. Care Management Requirements

1. PCP Role

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. Primary Care Providers (PCPs) are responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining continuity of care.[1]

PROCEDURES:

A. PCPs are responsible for coordinating care management services for assigned Members, when indicated.

B. PCPs are responsible for identifying Members who may potentially require care management services and notifying the IPA Care Management (CM) Department. PCPs may also submit a completed CM Referral Form to IEHP to refer the Member for care management. This form is found in the "Providers" portal of the IEHP website (www.iehp.org) (see Attachment, "IEHP Care Management Referral Form" in Section 25). IEHP shall coordinate with the Member's IPA, as needed. Members, who may benefit from care management include, but are not limited to:

   1. Members with complex medical or behavioral health conditions requiring multiple Providers or multiple interventions and care coordination needs;
   2. Any child with a potential California Children's Services (CCS) eligible condition or Members with suspected or confirmed developmental disabilities that may qualify for enrollment into Inland Regional Center/Early Start Program;
   3. Potential major organ transplant candidates;
   4. Members frequently accessing Emergency Room services;
   5. Members who live alone, are frail, have inadequate family support systems, need continuity of care services, and could benefit from Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS), and/or Multipurpose Senior Services Program (MSSP) services; and
   6. Any other Member who could benefit from CM services.

C. PCPs are responsible for referring Members to IEHP for health education classes, care management programs, and disease management programs.

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 1, Definitions

D. PCPs are responsible for coordinating care for the Member with the IPA CM or IEHP CM, including but not limited to contacting other clinicians or entities, facilitating the transfer of medical records as necessary and initiating specialty referrals.

E. PCPs are responsible for ensuring Members receive preventive care in accordance with IEHP's approved guidelines.

~~***Member Identification***~~***MEMBER IDENTIFICATION:***

- ~~IPAs are responsible for identifying Members that may benefit from care management through the following activities:~~
  - ~~At least monthly, IPAs analyze internal data such as claims, encounters, utilization, pharmacy, Member, ProviderProvider, and health plan referrals against the identification criteria described in their care management program description.~~
  - ~~IPAs analyze data that is made available to them by IEHP through the IEHP Provider portal and Secure File Transfer Protocol (SFTP) server. This data includes but is not limited to:~~
    - ~~Health Risk Assessment (HRA) for Seniors and Persons with Disabilities (SPD) Members;~~
    - ~~Health Information Form for newly enrolled Medi-Cal Members;~~
    - ~~MSSP care plans and health assessment summaries (if available and applicable);~~
    - ~~Individual Plan of Care from CBAS centers, CBAS Eligibility Determination Tool, and Discharge Summary (if available and applicable);~~
    - ~~IHSS service hours and county social worker's contact information (if available and applicable);~~
    - ~~Monthly reports that identify new CCS Members;~~
    - ~~Monthly reports that identify Members who are turning 21 years of age that will be transitioning out of CCS; and~~
    - ~~Monthly roster of children who are currently receiving services through IRC's Early Start Program~~

~~*Seniors and Persons with Disabilities (SPD)*~~***SENIORS and PERSONS with DISABILITIES:***

- ~~IEHP performs the HRA on SPD Members, which includes basic assessment questions needed to identify and determine what level of care management would be most appropriate for the Member.~~[2]

~~[2] DHCS APL 17-013 Supersedes Policy Letter (PL) 14-005, "Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities"~~

- The IPA will review all SPD HRAs on the secure IEHP Provider portal and/or the SFTP daily.
- The SPD HRA data that is made available to the IPA will identify the post-HRA risk level as High or Low. An HRA risk level of High indicates that the Member should be immediately reviewed by the IPA for care management needs.
- The IPA must have a process to enroll Members into a care management program appropriate for their risk level.
- The IPA's own risk assessment of the Member should include, at a minimum, the post-HRA risk score, utilization patterns, pharmacy data, medical history, behavioral health diagnosis, social determinants, enrollment into an LTSS program such as IHSS, CBAS or MSSP, and care management assessment data.

- If the IPA is unable to contact the Member to review the HRA or to complete an assessment, the IPA must make, at minimum, three (3) separate contact attempts to locate the Member.
  - Contact attempts must be made within thirty (30) calendar days of IEHP providing the HRA data to the IPA.
  - Attempts may be telephonic, by mail, by email, etc.
  - All contact attempts of the same type on the same day are considered one (1) attempt.
  - All contact attempts must be documented (see Attachment, "Monthly Care Management Log" in Section 25).
- The IPA must offer an Interdisciplinary Care Team (ICT) to all identified high-risk SPD Members when a need is demonstrated and in accordance with the Member's functional status, assessed need, and in the ICP. An ICT must also be available to these SPD Members upon their request.[3]
  - The ICT consists of, at a minimum, the Member and/or Member's authorized representative, the Member's caregiver, the Care Manager, the IHSS Social Worker (if the Member is receiving IHSS benefits), and the PCP or Specialist (if the Specialist is serving as the Member's PCP). Additional members may include social workers, Specialists, Medical Directors, IEHP staff, and other individuals that are actively involved in the Member's care.
  - The IPAs hold case conferences periodically, or at the Member's discretion. In addition, IEHP also recommends IPAs to consider a case conference after conducting the Member's annual assessment.

[3] DHCS APL 17-012

- IEHP holds case conferences on a regular basis and can support the IPA if assistance is needed. The IPA may contact IEHP Provider Relations Team at (909) 890-2054 for assistance with coordinating an ICT case conference.

- The IPA must develop an Individual Care Plan (ICP) for high-risk SPD Members and other Members that demonstrate a need for an ICP, or when requested by the Member, Provider, IEHP, or as described in the IPA's care management program description, policies and procedures.[4]
  - The IPA must develop the Member's ICP within thirty (30) business days of the HRA completion date. The Member's HRA completion date is found in the HRA data file sent to the IPA via SFTP and on the secure IEHP Provider portal.
  - The ICP must be developed based on the specific health care needs of the Member, and consider input from the Member, data obtained from the HRA, and input from the ICT if appropriate.
- The ICP must include, but not be limited to, the following elements, as appropriate:
  - Prioritized goals that are agreed upon by the Member;
  - Identified barriers to meeting the goals;
  - Development of a schedule for follow-up that adheres to the risk stratification and program description/policies of the IPA; and
  - Assessment of the Member's progress towards the goals and the ICP is adjusted as needed.
- ICPs must be reviewed as determined by the Member's individualized needs, including but not limited to:
  - A change in the Member's health condition, including but not limited to a change in the level of care;
  - A new problem has been identified with the Member;
  - A goal has changed priority, has been met or is no longer applicable; and
  - ICP is closed or completed.
- IEHP and its IPAs are required to offer and provide, upon request, a copy of the initial ICP and any of its amendments by mail to the Member at least annually.[5] Updates are telephonically provided during each follow up.[6] IEHP and its IPAs must offer to send a copy of the updated ICP to the Member in these scenarios, at minimum:

[4] DHCS APL 17-012
[5] Ibid.
[6] Ibid.

- ~~The ICP is completed or closed;~~
- ~~A change in the Member's condition (e.g., a change in the level of care); and~~
- ~~A new problem is identified with the Member and added to the ICP, as discussed with the Care Manager.~~

~~The ICP will be made available in alternative formats and in the Member's preferred written or spoken language upon request.[7]~~

~~E. The ICP must be shared with the Member and Provider and be made available to other members of the ICT~~

F. PCPs are responsible for referring Members to the appropriate Long-Term Services and Supports (LTSS) services when it is determined that the Member is a potential candidate for any of these LTSS services:

1. CBAS – See Policy 12H, "Community-Based Adult Services" for more information.
2. Long-Term Care (LTC) – See Policies 14F1, "Long-Term Care – Custodial Level," and 14F2, "Long-Term Care – Skilled Level" for more information.
3. IHSS – See Policy 12F, "In-Home Supportive Services" for more information.
4. MSSP – See Policy 12N, "Multipurpose Senior Services Program" for more information.

G. PCPs shall not charge a fee for the completion of certification forms, which is required for referral to the IHSS program.

H. PCPs are responsible for logging onto the secure IEHP Provider portal to review the Member's Health Risk Assessment (HRA) results and Individualized Care Plan (ICP) and incorporate the results into the Member's medical record.

I. PCPs are expected to participate in the development of the Member's ICP and in Interdisciplinary Care Team (ICT) case conferences, as needed.[8]

~~[7] DHCS APL 17-012~~

[8] DHCS All Plan Letter (APL) 17-012 Supersedes APL 14-010, "Care Coordination Requirements for Managed Long-Term Services and Supports"

12. COORDINATION OF CARE

A. Care Management Requirements

1. PCP Role

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 202~~2~~3

12. COORDINATION OF CARE

A. Care Management Requirements
2. Continuity of Care

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members.

POLICY:

A. IEHP and its IPAs ensure IEHP Members with pre-existing provider relationships who make a Continuity of Care (COC) request are given the option to continue treatment for up to twelve (12) months with an out-of-network Medi-Cal provider. These eligible Members may require COC for services they have been receiving through Medi-Cal Fee-For-Service (FFS) or another health plan.[1]

PURPOSE:

A. To achieve an improved quality of care, support coordination and continuity of care, increase Member satisfaction with care, and enhance system efficiencies.

PROCEDURES:

Continuity of Care

A. COC Requirements

1. COC extends to primary, specialty, durable medical equipment (DME), medical supplies, mental health, and select ancillary care providers, including physical therapy, occupational therapy, respiratory therapy, behavioral health therapy, and speech therapy providers.[2]

~~1. IEHP and its IPAs are not required to provide COC for services not covered by Medi-Cal. In addition, provider COC protections do not extend to durable medical equipment, transportation, ancillary services, and carved-out service providers.[3]~~

2. IEHP and its IPAs provide COC with an out-of-network provider when all the following requirements are met:[4]

   a. IEHP or the Member's IPA can determine that the Member has a~~n~~ pre-existing relationship with the provider:

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 22-032 Supersedes APL 18-008, "Continuity of Care for Medi-Cal Beneficiaries who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service, and for Medi-Cal Members who Transition into a New Medi-Cal Managed Care Health Plan On or After January 1, 2023~~Department of Health Care Services (DHCS) All Plan Letter (APL) 18-008 Supersedes APL 15-019, "Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care"~~

[2] Ibid.

[3] ~~Ibid.~~

[4] Ibid.

~~1) An existing relationship means the Member has seen the out-of-network Primary Care Provider (PCP) or specialist at least once during the twelve (12) months prior to the Member's initial enrollment with IEHP for a non-emergency visit.~~

~~2) Self-attestation is not sufficient to provide proof of a relationship with a provider.~~

b. The provider is willing to accept ~~accept payment from~~ IEHP's contract rates, ~~or~~ the Member's IPA contract ~~rates~~ based on ~~their rate for~~ the service offered or applicable Medi-Cal FFS rate, whichever is higher~~.~~ ;

c. IEHP or the Member's IPA determines that the provider meets applicable professional standards and has no disqualifying quality of care issues that would otherwise exclude the provider from their network;~~.~~ and

d. The provider is a California State Plan approved provider.

~~e. The provider supplies IEHP with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan if it is allowable under federal and state privacy laws and regulations.~~

3. If a Member ~~disenrolls from IEHP to~~ changes Medi-Cal managed care plans (MCPs) by choice following their initial enrollment in an MCP or if a Member loses and then later regains MCP eligibility during~~,~~ the ~~twelve (~~12~~)~~-month COC period, the 12-month COC period may start over one (1) time. If the Member changes MCPs a second time or more, the COC period does not start over, which means that the Member does not have the right to a new ~~twelve (~~12~~)~~ months of COC. If the Member returns to Medi-Cal FFS and later re-enrolls in an MCP, the COC period does not start over.[5] If the Member changes IPA during their enrollment with IEHP, the COC period does not start over.

The Member is assigned to IEHP or an IPA that has the Member's preferred PCP in its network. For example, if a Member has an existing relationship with a PCP and a specialist in IPA #1, as well as a specialist in IPA #2, IEHP assigns the Member to IPA #1, who is contracted with the Member's preferred PCP. IPA #1 is responsible for allowing the Member to continue treatment with both specialists, pursuant to COC requirements.

~~3.~~4.

B. Requesting for COC

1. Members, their authorized representative, or their Provider, may make a direct request to IEHP or the Member's IPA for COC. ~~When this occurs, IEHP or the Member's IPA begins to process the request within five (5) working days following the receipt of the~~

[5] DHCS APL ~~18-008~~22-032

~~request. The request, however, must be completed within three (3) calendar days if there is an imminent and serious threat to the health of the Member. The COC process begins when IEHP or the Member's IPA starts the process to determine if the Member has a pre-existing relationship with the provider.~~[6]

2. IEHP and its IPAs accept requests for COC over the telephone and do not require the ~~requester~~ requestor to complete or submit a paper or computer form if the requester prefers to request telephonically.[7]

3. IEHP provides acknowledgment of the COC request advising the Member that the COC request has been received, the date of receipt, and the estimated timeframe for resolution. Acknowledgement of COC request will be provided within the following timeframes, using the Member's known preference of communication or by one of these methods in the following order – telephone call, text message, and then notice by mail:[8]

   a. Within 7 calendar days of receipt of non-urgent requests; and

   b. Within the shortest applicable timeframe that is appropriate for the Member's condition, but no later than three (3) calendar days of receipt of urgent requests.

2. If requested by a newly enrolled or transitioning Member, their authorized representative, or provider, IEHP allows the Member to keep previously authorized and scheduled specialist appointments with out-of-network specialists when COC has been established and the appointment(s) occur within the 12- month COC period. [9]

   ~~1.~~a. If pre-existing relationship with the out-of-network provider has not been established, IEHP and its Delegates are encouraged to make a good faith effort to either, arrange for an alternative in-network Provider on or before the scheduled appointment date, or keep the appointment with the out-of-network provider. However, since the appointment with the out-of-network provider occurs after the Member's transition to IEHP, it does not establish the requisite pre-existing provider relationship for the Member to submit a Continuity of Care request.[10]

C. Medical Exemption Requests (MER)

[6] ~~Ibid.~~
[7] Ibid.~~Ibid.~~
[8] Ibid.
[9] Ibid.
[10] DHCS APL 22-032

1. A MER is a request for temporary exemption from enrollment into IEHP only until the Member's medical condition has stabilized to a level that would enable the Member to transfer to an in-network Provider without deleterious medical effects.[11],[12]

~~2.~~ IEHP and its IPAs consider MERs that have been denied as automatic COC requests to allow Members to complete their courses of treatment with Medi-Cal FFS providers.[13],[14]

2.

3. Regardless of the Member's IPA assignment, IEHP performs an initial outreach to these Members by mail and by phone to inform them of their COC rights.

~~a.~~4. IEHP outreaches to these Members per regulatory requirements and reaches out to the Member's IPA to complete the COC request within regulatory timeframes.

D. Retroactive Approval of COC Requests[15]

1. IEHP and its IPAs retroactively approve and reimburse out-of-network providers for services that were already provided if the claim meets all COC requirements described in this policy as well as the following:

   a. Services were provided after the Member's enrollment into IEHP; and

   ~~b. Dates of service were after December 29, 2014; and~~

   ~~c.~~b. Dates of service are within ~~thirty (~~30~~)~~ calendar days of the first service for which the provider requests retroactive COC reimbursement.

2. Retroactive COC reimbursement requests must be submitted within ~~thirty (~~30~~)~~ calendar days of the first service to which the request applies.

E. Validating Pre-Existing Provider Relationship[16]

1. A pre-existing relationship means the Member has been seen by the out-of-network Primary Care Provider (PCP), specialist, or select ancillary provider including physical therapy, occupational therapy, respiratory therapy, behavioral health treatment (BHT), and speech therapy provider for a non-emergency visit, at least once during the 12 months prior to the Member's initial enrollment with IEHP.

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[11] Ibid.
[12] DHCS APL 17-007 Supersedes APL 15-001, "Continuity of Care for New Enrollees Transitioned to Managed Care After Requesting a Medical Exemption and Implementation of Monthly Medical Exemption Review Denial Reporting"
[13] DHCS APL ~~18-008~~22-032
[14] DHCS APL 17-007~~ Supersedes APL 15-001, "Continuity of Care for New Enrollees Transitioned to Managed Care After Requesting a Medical Exemption and Implementation of Monthly Medical Exemption Review Denial Reporting"~~
[15] DHCS APL ~~18-008~~22-032
[16] Ibid.

~~1.~~2. IEHP and its IPAs determine if the Member has an existing relationship with the out-of-network provider through the following:

a. ~~Review of utilization data; and/or~~Review of data provided by DHCS or a terminating plan, such as Medi-Cal FFS utilization or claims data; and/or

~~b. Review of medical records; and/or~~

~~c.~~b. Information or documentation provided by the Member, their authorized representative, or their provider ~~demonstrating pre-existing relationship such as actual documentation~~ (self-attestation from the Member is not sufficient proof).

3. Upon validation of the Member's pre-existing relationship with the out-of-network provider, IEHP or the Member's IPA will contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement or other forms of relationship to establish ~~a~~ COC ~~relationship~~ for the Member.[17]

a. If the provider is in-network, the Member is allowed to continue seeing the Provider.

~~2.~~4. IEHP requests from the out-of-network provider all relevant treatment information, for the purposes of determining medical necessity, as well as current treatment plan, if it is allowable under federal and state privacy laws and regulations.

F. Completing COC Request

~~1. To ensure that decisions are rendered as expeditiously as required by the Member's condition, IEHP and its IPAs must develop and apply a standard for assessing the Member's medical condition and determining the urgency of their request. Evidence of the Member's condition can be obtained from the treating provider or from the Member's medical record (e.g., diagnosis, symptoms, or test results).~~

1. IEHP and it's IPAs begins to process a COC request within five (5) working days following receipt of the request. The COC process begins when IEHP starts the process to determine if the Member has a pre-existing relationship with the Provider.[18]

2. IEHP and its IPAs complete COC requests within the following timelines:[19]

a. ~~Thirty (~~30~~)~~ calendar days from the date of receipt of COC request;

b. ~~Fifteen (~~15~~)~~ calendar days from the date of receipt of the COC request if the Member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or

c. As soon as possible, but no longer than ~~Three~~ three (3) calendar days from ~~the date of receipt of the COC request if there is an imminent and serious threat to the health~~

[17] ~~Ibid.~~
[18] DHCS APL 22-032
[19] ~~DHCS APL 18-008~~Ibid.

~~of the Member~~ receipt of an urgent request (i.e., there is identified risk of harm to the Member).

~~e.~~ To ensure that decisions are rendered as expeditiously as required by the Member's condition, IEHP has developed and applies a standard for assessing the Member's medical condition and determining the urgency of their request.

3. A COC request is considered completed when:[20]
   a. IEHP or the Member's IPA notifies the Member that the request has been approved or denied;
   b. IEHP or the Member's IPA and the out-of-network provider are unable to agree to a rate;
   c. IEHP or the Member's IPA has documented quality of care issues with the out-of-network provider; or
   d. IEHP or the Member's IPA makes a good faith effort to contact the provider, and the provider is non-responsive for thirty (30) calendar days.
4. ~~Upon approval of a COC request,~~ IEHP or the Member's IPA notifies the Member of the decision, using the Member's preferred method of communication or by telephone, and by mail ~~following~~ within seven (7) calendar days of the decision.~~:~~[21]
   a. IEHP and it's IPAs include the following in approval notices:
      ~~a.~~1) ~~Approval of the COC request~~A statement of the Plan's decision;
      ~~b.~~2) Duration of the COC arrangement;
      ~~c.~~3) The process that will occur to transition the Member's care back into the network at the end of the COC period; and
      4) The Member's right to choose a different provider from IEHP's or the IPA's network.
   b. IEHP and it's IPAs include the following in denial notices:
      1) A statement of the Plan's decision;
      2) A clear and concise explanation of the reason for denial; and
      3) The Member's right to file a grievance or appeal.
      ~~d.~~

[20] ~~Ibid.~~
[21] DHCS APL 22-032 ~~Ibid.~~

IEHP or the Member's IPA must notify the Member utilizing the IEHP-approved "Continuity of Care Authorization Letter" template. These IEHP-approved notification templates are available online at: www.iehp.org.

5. If the provider meets all of the necessary requirements, including entering into a contract, letter of agreement, single-case agreement or other forms of relationship with IEHP or the Member's IPA, the Member is allowed to access the provider for the length of the COC period unless the provider is only willing to work with IEHP or the IPA for a shorter timeframe; in which case, IEHP or the IPA will allow the Member to have access to that provider for the shorter period of time.[22]

~~6.~~ IEHP and it's IPAs will work with the out-of-network provider and communicate its requirements on letters of agreements, including referral and authorization process, to ensure that Members are not referred to another out-of-network provider without authorization from the Plan. IEHP and it's IPAs will review requests for referrals and approve if the request is deemed medically necessary and if there is not an appropriate Provider available in-network.[23] ~~If IEHP or the IPA and the out-of-network provider are unable to reach an agreement, IEHP or the IPA will assign the Member an in-network alternative. Members maintain the right to pursue an appeal or grievance through the Medi-Cal processes.[24]~~

6.

7. IEHP an it's IPAs will work with providers to establish a plan of care for the Member.

8. If IEHP or the IPA and the out-of-network provider are unable to reach an agreement, or if the provider has documented quality of care issues, IEHP or the IPA will assign the Member an in-network alternative. If the Member does not make a selection, one will be assigned to them.

~~7. In cases where an approved out-of-network provider needs to refer a Member to another out-of-network provider, the approved out-of-network provider must first contact IEHP or the Member's IPA, who will review the request for referral and approve if the request is deemed medically necessary and if IEHP or the IPA does not have an appropriate provider within its network.[25]~~

G. Transitioning the Member's Care to an In-Network Provider[26]

[22] DHCS APL ~~18-008~~22-032
[23] Ibid.
[24] ~~Ibid.~~
[25] ~~Ibid.~~
[26] Ibid.

1. IEHP and its IPAs may choose to allow the Member continued access to the out-of-network provider past the ~~twelve (~~12~~)~~ month COC period; however, neither IEHP nor its IPAs are required to do so.
2. Members may change their provider to an in-network Provider at any time, regardless of whether a COC relationship has been established.
3. IEHP and its IPAs ~~must~~ notify the Member, using their preferred method of communications, ~~s~~ at least ~~thirty (~~30~~)~~ calendar days before the end of the COC period to assist in transitioning their care to an in-network Provider at the end of the COC period. This process includes engaging with the Member and the out-of-network provider before the end of the COC period to ensure continuity of services and patient safety through the transition to the in-network Provider.
    a. IEHP or the Member's IPA must notify the Member utilizing the IEHP-approved "Continuity of Care Terminate Letter" template. These IEHP-approved notification templates are available online at: www.iehp.org.

H. Covered California to Medi-Cal Transition[27]

~~1. No later than fifteen (15) days after their enrollment with IEHP, Members that transition from Covered California are informed through the Member Handbook about their right to request for COC.~~

~~2. IEHP and its IPAs are required to honor any prior treatment authorizations for up to sixty (60) days or until a new assessment is completed. A new assessment is considered completed if the Member has been seen by an in-network Provider, who then completes a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization.~~

1. Prior treatment authorizations must be honored without a request by the Member or the out-of-network provider.
2. For Members that undergo a mandatory transition from Covered California to Medi-Cal managed care, IEHP or the IPA will contact these Members by telephone, letter, or other preferred method of communication within 15 calendar days after enrollment to:
    a. Ask if there are upcoming health care appointment or treatment scheduled and assist them in initiating a COC request if the Member chooses to do so;
    b. Make a good faith effort to learn from and obtain information from the Member so that it is able to honor active prior treatment authorizations with a network Provider and/or establish COC.

[27] ~~DHCS APL 18-008~~Ibid.

~~3.~~ For Members that undergo a mandatory transition, IEHP or the IPA will honor any active prior treatment authorizations for covered services for 90 days from the date of enrollment, without a request by the Member, authorized representative, or provider. IEHP or the IPA will arrange for these services with an in-network Provider if possible, and an out-of-network Provider if a suitable in-network Provider is not able to be identified. After 90 days, the active authorization will remain in effect for the duration of the treatment authorization or until completion of a new assessment by IEHP, whichever is shorter.

3.

I. Fee-For-Service (FFS) Medi-Cal or Expiring Plan Transition[28]

1. Following a Member's mandatory transition from Medi-Cal FFS to IEHP, or from another plan with its contract expiring or terminating on or after January 1, 2023:

   a. Active prior treatment authorizations for services remain in effect for 90 days and will be honored without a request by the Member, their authorized representative, or Provider.

   b. IEHP will arrange for services authorized under the active prior treatment authorization with a in-network Provider. If a suitable in-network Provider cannot be arranged within time and distance standards, care from an out-of-network Provider will be arranged.

   c. After 90 days, the active treatment authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by IEHP, whichever is shorter.

   d. If IEHP does not complete a new assessment, the active treatment authorization remains in effect and after 90 days, IEHP may reassess the Member's prior treatment authorization at any time.

~~I.~~ When reassessing enhanced care management (ECM) authorizations after 90 days, IEHP will reassess against ECM discontinuation criteria, not the ECM Population of Focus Eligibility criteria.~~Seniors and Persons with Disabilities~~

~~1.~~2. ~~IEHP and its IPAs are required to honor any active FFS Treatment Authorization Requests (TARs) for up to sixty (60) days or until a new assessment is completed. A new assessment has been completed when the Member has been seen by a contracted Provider and this Provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active Prior Treatment Authorization. The FFS TAR must be honored as outlined above without a request by the Member or the Provider.~~

[28] DHCS APL 22-032

J. Non-Specialty Mental Health Services

1. In both Riverside and San Bernardino Counties, Medi-Cal specialty mental health services (SMHS) are organized through the County Behavioral/Mental Health Departments. Riverside and San Bernardino County Behavioral/Mental Health Agencies are responsible for providing medically necessary behavioral health services to children and SMHS to adults (ages 21 and older) who meet county Tier III SMHS criteria. Please see Policy 12K1, "Behavioral Health Services" for more information.
2. IEHP provides COC with an out-of-network SMHS provider, when the Member's mental health condition has stabilized such that the Member no longer qualifies to receive SMHS from the County Behavioral/Mental Health Departments and instead becomes eligible to receive non-SMHS from IEHP. In this situation, COC protections only apply to psychiatrists and/or mental health provider types permitted by Medi-Cal to provide outpatient non-SMHS.[29]
3. If the Member later requires SMHS from the County Behavioral/Mental Health Department to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to IEHP for non-SMHS, the 12-month COC period may start over one (1) time only.[30]

K. Behavioral Health Treatment (BHT) for Members[31]

1. For BHT services, an existing relationship means a Member has seen the out-of-network BHT provider at least one (1) time during the ~~six~~ twelve (~~6~~12) months prior to either the transition of services from a Regional Center to IEHP or the date of the Member's initial enrollment in IEHP ~~if enrollment occurred on or after July 1, 2018~~.[32]
2. Retroactive requests for BHT COC reimbursement are limited to services provided after a Member's transition date into IEHP or the date of the Member's enrollment with IEHP if the enrollment date occurred after the transition.
3. ~~3.~~ IEHP must consider every Member transitioning from a Regional Center as an automatic COC request.
3.

L. Durable Medical Equipment (DME) and medical supplies[33]

1. IEHP and it's IPAs allow transitioning Members to keep their existing DME rentals and medical supplies from their existing Provider, under the previous prior authorization for

[29] DHCS APL 22-032~~Ibid.~~
[30] ~~DHCS APL 18-008~~Ibid.
[31] Ibid.
[32] Ibid.
[33] Ibid.

a minimum of 90 days following enrollment with IEHP and until IEHP or the IPA is able to reassess.

2. Continuity of DME and medical supplies is honored without need for request by the Member, their authorized representative, or Provider.

3. If DME or medical supplies have been arranged for a transitioning Member, but have not yet been delivered, IEHP and it's IPAs allow for delivery and for the Member to keep the DME or medical supplies for a minimum of 90 days following enrollment and until IEHP or the IPA is able to reassess.

4. If IEHP or the IPA does not complete a new assessment, authorizations for DME and medical supplies remain in effect for 90 days, after which IEHP and it's IPAs may reassess the Member's authorization at at any time and require the Member to switch to a network DME Provider.

M. Transportation[34]

1. IEHP allows Members to keep the modality of transportation under previous prior authorizations with a network Transportation Provider, until IEHP is able to reassess the Member's continued transportation needs.

~~L.~~N. Other COC Provisions

1. IEHP informs Members upon their enrollment through the Member Handbook (Evidence of Coverage) of their COC protections, including how Members, their authorized representatives, and Providers can initiate a COC request. This information is also accessible via the IEHP website. The Member Handbook and all Member-informing materials are translated into IEHP's threshold languages and are available in alternative formats, upon request.[35]

~~2.1. The Member is assigned to IEHP or an IPA that has the Member's preferred PCP in its network. For example, if a Member has an existing relationship with a PCP and a specialist in IPA #1, as well as a specialist in IPA #2, IEHP assigns the Member to IPA #1, who is contracted with the Member's preferred PCP. IPA #1 is responsible for allowing the Member to continue treatment with both specialists, pursuant to COC requirements.~~

[34] DHCS APL 22-032
[35] Ibid.

~~3.~~2. Newly enrolled Members currently residing in long-term care at a Skilled Nursing Facility (SNF) will be granted COC for 12 months and will not be required to relocate prior to their enrollment as long as the facility meets the following criteria:~~36.~~37

a. Facility is licensed by the California Department of Public Health (CDPH);

b. Facility is enrolled as a Provider in Medi-Cal;

c. Meets acceptable quality standards; and

d. Facility and IEHP agree to rates that meet state statutory requirements.

Members currently in a LTC do not have to make a request to IEHP to invoke the above provision.

3. IEHP uses treatment authorization request (TAR) and/or prior authorization data to identify prior treatment authorizations, including authorized procedures and surgeries, and existing authorizations for DME and medical supplies. IEHP pays claims for prior and existing authorizations when data is incomplete.

4. Members have the right to file their grievance at any time following any incident or action that is the subject of the Member's dissatisfaction during the COC process. Please refer to Policy 16A1, "Grievance and Appeals Resolution Process – Member Rights and Options" for more information.

5. Members have the right to seek review of IEHP's final decisions as well as obtain copies of this policy. Members desiring review of a decision, or wanting a copy of this policy, should contact IEHP's Member ~~Services Department~~Call Center at (800) 440-4347.

6. IEHP reports on existing metrics related to COC provisions as outlined in state and federal guidance materials.[38]

~~5.~~7. All Members have the right to continue receiving Medi-Cal services covered under the MCP's contract. IEHP or the Member's IPA will arrange for continuity of care for covered services without delay to the Member with an in-network Provider, or if there is no in-network Provider available within applicable timeframes and access standards, with a suitable out-of-network provider. If a Member would like their out-of-network provider to provide a service, they can submit a request for COC in accordance with this policy.

Obtaining Care from Terminating or Out-of-Network Providers

~~[36] DHCS-IEHP-Two-Plan-Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 21, Provision 7, Covered Services~~

[37] DHCS APL ~~22-018~~23-004 Supersedes APL 22-018 "Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care

[38] Ibid.

12. COORDINATION OF CARE

A. Care Management Requirements
2. Continuity of Care

A. Upon their request, current or newly enrolled Members with specified conditions may continue to obtain health care services from a Provider ending their contract with their IPA. This is not applicable to Providers with disciplinary actions or sanctions or a non-contracted provider for a specific timeframe as noted below.[39]

1. Acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

2. Serious chronic condition is a medical condition due to a disease, illness, medical problem, or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration~~, or terminal illness~~. Completion of covered services shall be provided for a period necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health plan in consultation with the Member and the terminating or nonparticipating provider. Completion of covered services shall not exceed 12 months from the provider's contract termination date or 12 months from the effective date of coverage for a newly covered Member.[40]

3. ~~For Members in the 2nd or 3rd trimesters of~~ Throughout the Member's pregnancy, which includes three (3) trimesters of the Member's pregnancy and the ~~immediate~~ first 12 months into the post-partum period~~, services shall be covered for the duration of the pregnancy and the first twelve (12) months into the postpartum period~~.[41], [42], [43]

4. For Members who present written documentation of being diagnosed with a maternal mental health condition from their treating provider, completion of covered services shall not exceed ~~twelve (~~12~~)~~ months from the diagnosis or from the end of pregnancy, whichever occurs later.[44]

5. Care of a newborn child between birth and age 36 months. Completion of covered services shall not exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a newly covered Member.

6. Performance of a surgery or other procedure that is authorized by IEHP or the IPA as part of a documented course of treatment and has been recommended and documented

[39] CA Health & Saf. Code § 1373.96
[40] DHCS APL 22-032
[41] H.R. 1319, the American Rescue Plan Act of the 117th Congress 2021–2022 (ARPA) (Pub. Law 117-2), Section 9812 "Modification to Certain Coverage Under Medicaid for Pregnant and Postpartum Women"
[42] NCQA, 2023 HP Standards and Guidelines, NET 4, Element B, Factor 2
[43] CA HSC§ 1373.96
[44] Assembly Bill (AB) 577, Eggman. Health care coverage: maternal mental health

by the Provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered Member.

7. Completion of covered services of a Member with a documented terminal illness. Completion of these covered services are provided for the duration of the terminal illness, even if it exceeds 12 moths from the contract termination date or 12 months from the Member's enrollment.[45]

~~5.~~B. If IEHP or the IPA is unable to come to an agreement with a terminated or out-of-network Provider, or if the Member, their authorized representative, or their Provider fails to submit a request for completion of covered services, IEHP is not required to continue to cover the Provider's services. In these instances, IEHP will assist the Member with obtaining care from a suitable in-network alternative.[46]

~~B.~~C. IEHP or the IPA's Medical Director is responsible for determining whether the Member may continue to obtain care from their terminating or out-of-network provider.

1. In determining whether or not a Member remains under the care of their current practitioner or maintains a previously scheduled treatment/procedure, the most important factor considered is the impact that a change of Practitioner or change in treatment/procedure has on the clinical status of the Member.
2. Care may continue beyond the specified timeframe if necessary, for a safe transfer to another practitioner.
3. If the decision is made to have the Member continue receiving care through their current practitioner, or maintain their previously scheduled treatment or procedure, the Member's IPA and/or Hospital is financially responsible per the IEHP Capitated Agreement.

~~C.~~D. Members currently under the care of a terminating provider are notified by IEHP or the Member's IPA to avoid disruption in care. Please see Policy 18J, "Termination of PCPs, Specialists, Vision, and Behavioral Health Providers" for information on Plan and IPA responsibilities.

~~D.~~E. If a Member is under the care of a Provider, whose IPA terminates their contract with IEHP, the health plan will make all efforts to assist the Provider with contracting with IEHP or another IPA within the health plan's network.

~~E.~~F. Unless otherwise agreed upon by the terminating Provider and IEHP or by the terminating provider and an IPA, the services rendered under this Policy will be ~~compensated~~ reimbursed at rates and methods of payment similar to those used by IEHP or the IPA for currently

[45] DHCS APL 22-032
[46] DHCS APL 22-032

contracted Providers providing similar services who are not capitated and who are practicing in the same geographic area as the terminating Provider.

~~F.~~G. For information on block transfers in the event of the termination of a provider contract, please see Policy 18J, "Termination of PCPs, Specialists, Vision, and Behavioral Health Providers."

12. COORDINATION OF CARE

A. Care Management Requirements
2. Continuity of Care

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2016
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

12. COORDINATION OF CARE

A. Care Management Requirements
3. Health Risk Assessment

APPLIES TO:

A. This policy applies to Seniors and ~~p~~Persons with ~~d~~Disabilities (SPDs), who meet the definition of "high risk" and Members who may need Long-~~-~~Term Services and Supports (LTSS) ~~Services.~~[1] ~~all IEHP Medi-Cal Seniors and Persons with Disabilities (SPD).~~

POLICY:

A. IEHP makes every effort to contact all newly enrolled high risk SPD Members and Members who may need LTSS, excluding Members who are in hospice, or in Long Term Care (LTC) facilities, to conduct the Health Risk Assessment (HRA) survey within regulatory timeframes from the effective date of identification. ~~the Member's enrollment.~~[2]

PURPOSE:

A. To ensure the timely assessment of newly enrolled high risk SPD Members and Members who may need LTSS. The assessment will aid ~~and~~with identification of their medical, functional, cognitive, and/or psychosocial health care needs that may require coordination of essential care and services.

PROCEDURES:

Initial Member Stratification

A. IEHP performs initial risk stratification for all newly enrolled SPD Members to stratify them to either a high or low risk. IEHP uses a risk stratification mechanism, or algorithm, to analyze Member-specific health care utilization data for newly enrolled SPD Members. The resources utilized to stratify newly enrolled SPD Members are as follows:[3]

1. Historical Medi-Cal fee-for-service utilization data from the Department of Health Care Services (DHCS), which may include but not be limited to:
    a. Emergency Room Data;
    b. Inpatient/Outpatient Data:
    c. Ancillary Services Data (for the most recent 12 months); and
    d. Pharmacy Data

B. SPD Members who meet the following are considered "high risk":[4]

[1] ~~Ibid.~~Department of Health Care Services (DHCS) CalAIM: Population Health Management (PHM) Policy Guide
[2] ~~Department of Health Care Services (DHCS) All Plan Letter (APL) 17-013 Supersedes Policy Letter (PL) 14-005, "Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities"~~[2]
[3] ~~CalAIM: Population Health Management (PHM) Policy Guide~~Ibid. ~~Ibid.~~
[4] Ibid.

~~1.~~ Members ~~Members who have been a~~authorized to receive: ~~IEHP-developed criteria and algorithms for complex care management including HIF/MET data when available.~~

1.

a. In-Home Supportive Services (IHSS) greater than, or equal to, 195 hours per month.

b. Community-Based Adult Services (CBAS), and/or

c. Multipurpose Senior Services Program (MSSP) Services

2. Members who:[5]

a. Have been on oxygen within the past 90 days~~.~~;

b. Are residing in an acute hospital setting;

c. Ha~~s~~ve been hospitalized within the last 90 days or has had three (3) or more voluntary and/or involuntary hospitalizations within the past year~~.~~;

d. Ha~~s~~ve had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g., multiple prescriptions consistent with the diagnoses of chronic diseases)~~.~~;

e. Have a behavioral health diagnosis or developmental disability in addition to one (1) or more chronic medical diagnoses or a social circumstance of concern (e.g., homelessness);

f. Have End-~~-~~Stage Renal Disease, Acquired Immunodeficiency Syndrome (AIDS), and/or a recent organ transplant~~.~~;

g. Ha~~s~~ve cancer and ~~is~~are currently being treated~~.~~;

h. Are pregnant;

i. Ha~~s~~ve been prescribed anti-psychotic medication within the past 90 days~~.~~;

j. Ha~~s~~ve been prescribed 15 or more medications in the past 90 days;~~:~~ ~~or~~

k. Have a self-report of a deteriorating condition; and/or

l. Ha~~s~~ve other conditions as determined by ~~the MCP~~IEHP, based on local resources.

~~B.~~C. All new Members who have no historical data will be stratified as high risk.[6]

Health Risk Assessment Survey Tool

A. IEHP uses a standardized survey tool that is based on DHCS requirements to assess medical,

[5] DHCS CalAIM: Population Health Management (PHM) Policy Guide
[6] ~~Ibid.~~

cognitive, functional needs and psychosocial status of the Members. This survey tool:[7]

1. Includes Long-Term Services and Supports (LTSS) referral questions, which are intended to assist in identifying Members who may qualify for and benefit from LTSS services; and
2. Incorporates stakeholder and consumer's input from sources such as the Persons' with Disabilities Workgroup (PDW).

B. The HRA survey is an assessment tool which identifies primary, acute, long-term services and supports, behavioral health and functional needs. For all Members, the HRA process will identify, at a minimum:

1. Referrals to appropriate Long-Term Services and Supports (LTSS) and home- and community-based programs;
2. Caregivers, Members, and authorized representatives' participation;
3. Facilitation of timely access to primary care, specialty care, durable medical equipment (DME), medications, and other health services needed by the Member, including referrals to resolve physical or cognitive barriers to access;
4. Facilitation of communication among the Member's providers, including Behavioral Health Providers as appropriate;
5. Identification of the need for providing other activities or services needed to assist Members in optimizing health or functional status, including assisting with self-management skills or techniques, health education, and other modalities improve health or functional status; and
6. Support for Members who need more complex case management.

HRA Survey Completion

. Following the initial risk stratification, IEHP makes every effort to contact newly enrolled SPD Members to conduct the HRA survey as follows:[8,9,10]

2.A. Following the initial risk stratification, Members identified as higher risk are contacted by IEHP to initiate the HRA within 30 days of identification and completinge the assessment within 60 days of that identification. to conduct the HRA within 45 days of the Member's enrollment.

2. Following the initial risk stratification, Members identified as lower risk are contacted

[7] DHCS APL 17-013
[8] Ibid.
[9] DHCS IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 4, "Health Risk Stratification and Assessment for SPD Beneficiaries"
[10] CA Welf. & Inst. Code § 1482(c)(12)(A)

~~by IEHP to conduct the HRA within 105 days of the Member's enrollment.~~

B. IEHP respects Members' right to decline/refuse to participate in the completion of the HRA. ~~These Members are identified in the medical management system for reassessment, at least annually or as Members' health conditions change.~~

C. ~~IEHP uses a risk stratification mechanism, or algorithm, to analyze Member-specific health care utilization data for newly enrolled SPD Members. This data is used as a reassessment and identifier of circumstances or conditions that require redetermination of risk level. At any given time, if the Member's medical condition changes and warrants an HRA, IEHP re-assesses the Member's health status.~~ IEHP assists with the completion of the HRA if the Member or their authorized representative require assistance.[11]

~~C. There is no annual re-assessment requirement for Seniors and Persons with Disabilities (SPD).[12]~~

IEHP and IPA Responsibilities

A. IEHP performs the HRA on SPD Members who meet the definition of "high risk" and Members who may need LTSS, which includes basic assessment questions needed to identify and determine what level of care management would be most appropriate for the Member.[13]

1. IPAs are expected to retrieve and review all SPD HRAs from the secure IEHP Provider portal and/or the Secure File Transfer Protocol (SFTP) daily.
2. The SPD HRA data that is made available to the IPA will identify the post-HRA risk level as High or Low. An HRA risk level of High indicates that the Member should be immediately reviewed by the IPA for care management needs.
3. The IPA must have a process to enroll Members into a care management program appropriate for their risk level.

~~3.~~4. The IPA can refer Members to IEHP for additional program enrollment. The IPA can submit a CM Referral Form to IEHP via email at CMreferralteam@iehp.org. (See Attachment, "IEHP Care Management Referral Form – Medi-Cal" in Section 25).

~~4.~~5. The IPA's own risk assessment of the Member should include, at a minimum~~, the post-HRA risk score~~, utilization patterns, pharmacy data, medical history, behavioral health diagnosis, social determinants, enrollment into an LTSS program such as IHSS, CBAS or MSSP, and care management assessment data.

B. The IPA must contact the Member to review the HRA or to complete an assessment~~If the IPA is unable to contact the Member to review the HRA or to complete an assessment,~~. ~~If the IPA~~

~~[11] DHCS APL 17-013~~

~~[12] CalAIM: Population Health Management (PHM) Policy Guide~~
[13] DHCS CalAIM: Population Health Management (PHM) Policy Guide ~~Ibid.~~

~~is unable to contact the Member, t~~The IPA must make, at minimum, three (3) separate contact attempts to locate the Member.

1. Contact attempts must be made within ~~thirty (~~30~~)~~ calendar days of IEHP providing the HRA data to the IPA.
2. Attempts may be telephonic, by mail, by email, etc.
3. All contact attempts of the same type on the same day are considered one (1) attempt.
4. All contact attempts must be documented (see Attachment, "Monthly Care Management Log" in Section 25).

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2023
Chief Title: Chief Medical Officer	**Revision Date:**	

~~INLAND EMPIRE HEALTH PLAN~~		
~~**Chief Approval:** *Signature on file*~~	~~**Original Effective Date:**~~	~~January 1, 2023~~
~~**Chief Title:** Chief Medical Officer~~	~~**Revision Date:**~~	

12. COORDINATION OF CARE

A. Care Management Requirements
4. Individualized Care Plan

APPLIES TO:

A. This policy applies to all IEHP ~~Medi-Cal~~ Seniors and Persons with Disabilities (SPDs), who meet the definition of "high risk" and Members who may need Long-Term Services and Supports (LTSS).[1]

POLICY:

A. IEHP and its IPAs must develop an Individualized Care Plan (ICP) for high-risk SPD Members, Members who may need LTSS, and other Members that demonstrate the need for an ICP, or when requested by the Member,[2] and coordinate referrals for identified Long-Term Services and Supports (LTSS), as needed.[3][4]

PURPOSE:

A. To ensure that IEHP Members with multiple or complex medical conditions are identified and that ICPs are developed to assist in the management of Members' health care needs.

B. To have a centralized plan for Members' comprehensive care goals that may include physical, behavioral, psychosocial, long-term services and supports ~~care~~ and spiritual needs.

DEFINITION:

A. Individualized Care Plan (ICP) – Plan of care developed in collaboration with the Member and their Interdisciplinary Care Team (ICT).

~~A.~~B. High Risk SPDs – See Policy 12A3, "Care Management Requirements – Health Risk Assessment."

PROCEDURES:

A. The IPA must develop an Individualized Care Plan (ICP) for high-risk SPD Members and other Members that demonstrate a need for an ICP, or when requested by the Member, Provider, IEHP, or as described in the IPA's care management program description, policies and procedures.[5]

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[1] Department of Health Care Services (DHCS) CalAIM: Population Health Management (PHM) Policy Guide
[2] ~~Department of Health Care Services (DHCS) All Plan Letter (APL) 17-012 Supersedes APL 14-010, "Care Coordination requirements for Managed Long-Term Services and Supports"~~
[3] ~~DHCS APL 17-013 Supersedes Policy Letter 14-005, "Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities"~~
[4] ~~DHCS IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 21, Provision 8, Coordination of Care~~
[5] ~~DHCS APL 17-012~~

1. The IPA must develop the Member's ICP within thirty (30) business days of the HRA completion date. The Member's HRA completion date is found in the HRA data file sent to the IPA via Secure File Transfer Protocol (SFTP) and on the secure IEHP Provider portal.

~~1. The IPA can refer complex Members to IEHP for additional program enrollment The IPA can submit a CM Referral Form to IEHP via email at CMreferralteam@iehp.org~~

2. The ICP must be developed based on the specific health care needs of the Member, and consider input from the Member, data obtained from the HRA, and input from the ICT, if appropriate.
    a. The ICP can be developed without having an HRA but must be developed with input from the Member and/or their authorized representative.
    b. Other information sources include but are not limited to utilization and pharmacy data, assessments for Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS) and Multipurpose Senior Services Program (MSSP).

3. The ~~The~~ IPA ~~can~~may refer to IEHP complex Members that may benefit from Complex Case Management services by submitting ~~to IEHP for additional program enrollment The IPA can submit~~ a CM Referral Form ~~to IEHP~~ via email at CMreferralteam@iehp.org. See Policy 12I, "Complex Case Management" for information about this program.

B. The Care Manager works with the Member to prioritize goals according to the Member's preference. Members are involved in the development, review, and approval of the ICP and any amendments to the ICP, as appropriate.[6]

C. The ICP is a tool that communicates Members' goals and preferences to ICT members. The ICP is an established set of problems, goals, interventions, and barriers which guide the course of care management and assist the Member with achieving health and wellness outcomes in the least restrictive and most inclusive setting. The ICP must include, but not be limited to, the following elements, as appropriate:
    1. Plan for addressing Member concerns, preferences, and goals, including responsible person and due date for follow up; [7]
    2. Measurable objectives and timetables to meet the physical health, behavioral health, and Long-Term Services and Supports (LTSS) needs as determined through HRA process, IHSS assessment results, MSSP assessment, and CBAS records, and input from members of the ICT as appropriate;
    3. Identification of barriers;
    4. Timeframes for reassessment;

[6] DHCS CalAIM: Population Health Management (PHM) Policy Guide~~APL 17-012~~
[7] Ibid.

5. Coordination of carved out and linked services, and referrals to appropriate community resources and other agencies such as IHSS, CBAS, and MSSP, when appropriate; [8] and
6. Care coordination needs such as arranging transportation, obtaining appointments, referral status updates, educating on interpreter services resources and the importance of preventive services.

D. ICPs must be reviewed as determined by the Member's individualized needs, including but not limited to, when:

1. There has been a change in the Member's health condition, including but not limited to a change in the level of care;
2. A new problem has been identified with the Member;
3. A goal has changed priority, has been met or is no longer applicable; and
4. ICP is closed or completed.

~~E. IEHP and its IPAs are required to provide to the Member or their authorized representative the opportunity to review and approve the ICP and any of its amendments.[9] IEHP and its IPAs must offer to send a copy of the updated ICP to the Member in these scenarios, at minimum:~~

~~1. The ICP is completed or closed;~~

~~2. A change in the Member's condition (e.g., a change in the level of care);[10] and~~

~~3. A new problem is identified with the Member and added to the ICP, as discussed with the Care Manager.~~

~~F. The ICP will be made available in alternative formats and in the Member's preferred written or spoken language upon request.[11] The ICP must be shared with the Member and Provider and be made available to other members of the ICT.~~

[8] Ibid.~~Ibid.~~
[9] ~~DHCS APL 17-012~~
[10] ~~Ibid.~~
[11] ~~Ibid.~~

12. COORDINATION OF CARE

A. Care Management Requirements
4. Individualized Care Plan

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2023
Chief Title: Chief Medical Officer	**Revision Date:**	

12. COORDINATION OF CARE

A. Care Management Requirements

5. Interdisciplinary Care Team

APPLIES TO:

A. This policy applies to all IEHP ~~Medi-Cal~~ Seniors and Persons with Disabilities (SPDs), who meet the definition of "high risk" and Members who may need Long-Term Services and Supports (LTSS).[1] ~~.~~

POLICY:

A. IEHP and its IPAs ensure that an interdisciplinary care team (ICT) is offered to all high-risk SPD Members, ~~and~~ Members who may need LTSS and those who request one, when a need is demonstrated and in accordance with the Member's functional status, assessed need, and their individualized care plan (ICP).[2]

PURPOSE:

A. To provide a multi-disciplinary approach to assessing, monitoring, and coordinating the care of a targeted population.

B. To address the multiple issues that affect these Members (e.g. medical, behavioral health, psychosocial, cognitive, and functional issues).

C. To promote a collaborative, interdisciplinary, Member-focused, and interactive approach to developing, implementing, and monitoring individualized Member care plans.

D. Manage communication and information flow regarding referrals, transitions, and care delivered outside the primary care site.

DEFINITION:

A. Interdisciplinary Care Team (ICT) – A team of individuals who are involved in the Member's health care. The team is person-centered and will collaborate with the Member and each other to assist in the development of an individualized care plan and assist in the coordination of the Member's health care needs.[3]

B. High Risk SPDs – See Policy 12A3, "Care Management Requirements – Health Risk Assessment."

~~A.~~

[1] Department of Health Care Services (DHCS) CalAIM: Population Health Management (PHM) Policy Guide
[2] ~~Department of Health Care Services (DHCS) All Plan Letter (APL) 17-012 Supersedes 14-010, "Care Coordination requirements for Managed Long-Term Services and Supports"~~
[3] Ibid.

PROCEDURES:

ICT Composition

A. ICT is led by professionally knowledgeable and credentialed personnel and consists of the following, at minimum:[4]

1. Member and/or Member's authorized representative;
2. Family member and/or caregiver, as approved by the Member;
3. Care Manager; and
4. Primary Care Provider (PCP) or Specialist if the Specialist is serving as the Member's PCP.

B. IEHP and its IPAs include individuals and/or Providers, who are actively involved in the Member's care and are willing to participate, as approved by the Member. Members may request the exclusion of any ICT member. Examples include, but are not limited to the following individuals:[5]

1. Hospital discharge planner such as IEHP and/or IPA Utilization Management staff (inpatient/outpatient nurses);
2. Nursing facility representative;
3. Social Worker, including the IHSS social worker if IHSS services are provided;
4. Specialized Providers, such as Member's Physician Specialists, Pharmacists, Physical Therapists, and Occupational Therapists;
5. If receiving In-Home Supportive Services (IHSS) and authorized by the Member, the IHSS Provider;
6. If participating in Community-Based Adult Services (CBAS), the CBAS Provider;
7. If enrolled in the Multipurpose Senior Services Program (MSSP), the MSSP case manager;
8. Behavioral Health Provider, which may include, but is not limited to, a specialty mental health Provider, county BH Provider or a substance use disorder counselor;
9. Dementia care specialist, as needed; and
10. Other professionals, as appropriate.

[4] ~~Ibid.~~DHCS CalAIM: PHM Policy Guide
[5] ~~DHCS APL 17-012~~

C. The Member, or authorized representative, has the primary decision-making role in identifying needs, preferences, and strengths and has a shared decision-making role in determining the services and supports that are most effective and helpful.

ICT Function and Communication

A. IEHP and its IPAs perform the following functions through the ICT:[6]

1. Facilitate care management, including assessment, care planning, authorization of services, and transitional care issues;
2. Work closely with the Member's PCP, Specialists, and other Providers involved in the Member's care to stabilize their medical conditions, increase compliance with care plans, maintain functional status, and meet the Member's care plan goals;
3. Develop and implement an ICP with participation from the Member and/or their caregiver;
4. Conduct ICT meetings periodically, or at the Member's request;
5. Manage communication and information flow regarding referrals, transitions, and care delivered outside the primary care site;
6. Maintain a call line or other mechanism for Member inquiries and input, as well as, a process for referring to other agencies, such as LTSS, IHSS, or Behavioral Health agencies, as appropriate;
7. Conduct conference calls to facilitate communication among ICT members, the Member and/or their caregiver;
8. Maintain a mechanism for monitoring Member complaints and grievances, which is provided to IPAs by IEHP; and
9. Use secure email, fax, web portals or written correspondence to communicate while taking the Member's individual needs, communication, cognitive, or other barriers into account.

D. IEHP and its IPAs have a process to assemble the ICT in the form of a case conference. Examples of situations which may require a formal case conference with the members of the ICT are as follows:

1. A Member or IEHP requesting the ICT be assembled to discuss the Member's issues;
2. Need to assess a Member, who is not achieving goals as stated on the ICP;
3. Need to assess a Member receiving care out-of-network;
4. Need to assess a Member transitioning from one (1) health setting to another or moving

[6] ~~Ibid.~~DHCS CalAIM: PHM Policy Guide

from one level of care management to another risk level;

5. Homebound Members that require a face-to-face assessment;
6. Members needing complex care coordination (i.e. homelessness, homebound, multiple co-morbidities, dual diagnosis, etc.); or
7. Members needing LTSS benefit coordination as well as other complex cases.

E. IPAs are responsible for documenting all invitees and attendees of the ICT, as well as offering and providing an updated ICP to the Member and the ICT as the Member's health status changes. If the IPA does not have a certain discipline type available to them, they may utilize the members of IEHP's ICT. These include Behavioral Health & Care Management (BH&CM) staff, Pharmacists, Independent Living and Diversity Program staff, LTSS care managers, Health Education staff, and dieticians.

F. IEHP has case conferences on a regular basis and can support the IPA if assistance is needed. The IPA may contact the IEHP BH&CM Department via email at CMGM@iehp.org or by calling Provider Relations Team at (909) 890-2054 if it needs assistance with coordination of the ICT case conference.

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12. COORDINATION OF CARE

~~C.~~B. California Children's Services

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members under the age of 21 with potential California Children's Services (CCS) eligible conditions.

POLICY:

A. IEHP ensures that Members under the age of 21 with potential CCS-eligible conditions are identified and referred to the local CCS program.[1]

B. CCS is a county-administered program that covers the most serious medical conditions of a physical nature that can be cured, improved, or stabilized. The program provides diagnostic services, medical treatment, and case management to children with conditions eligible for treatment under the CCS program. Eligible conditions may include, but are not limited to:

1. Birth defects (such as congenital heart disease);
2. Chronic illnesses (such as cystic fibrosis);
3. Malignancies; and
4. Certain serious injuries and physical disabilities.

PROCEDURES:

Identification CCS Cases

A. Primary Care Providers (PCPs) and Specialty Care Providers are responsible for performing appropriate baseline health assessments and diagnostic evaluations sufficient to establish the identification of Members with potential CCS eligible conditions and directly referring to CCS-paneled Providers and CCS-approved Hospitals within IEHP network, as well as the CCS program.[2]

B. Members with potential CCS-eligible conditions may be identified at any medical encounter, through UM authorization activity or care management interactions by IPA or hospital-based staff.

Referral to CCS

A. CCS offers various program components. Please refer to the following website for more information about the programs CCS offers: https://www.dhcs.ca.gov/services/ccs/Pages/ProgramOverview.aspx.

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 9, California Children's Services (CCS)
[2] Ibid.

~~C.~~B. California Children's Services

B. Upon identification of a CCS-eligible condition, Providers and IPAs are responsible for referring the Member to the appropriate County CCS Program.

1. PCPs may refer children under the age of 21 to the local CCS program by email, or fax.[3]

C. PCPs, Specialty Care Providers or the Member's IPA are responsible for the completion of referral forms (See Attachments, "CCS-GHPP Client Service Auth Request - New Case" and "CCS-GHPP Client Service Auth Request – Established Case" in Section 12). The CCS referral form includes information including type of requested service, diagnosis, history and management plan, number of days requested, and specific NICU information when necessary. Applicable medical records and a Service Authorization Request for CCS should be submitted to one (1) of the following entities:

Riverside County Residents
Riverside County CCS Program
10769 Hole Ave., Ste. 220
Riverside, CA 92505
Phone: (951) 358-5401 ~~or~~
~~(866) 735-4227~~
Fax: (951) 358-5198

Referral Must Be Faxed To:
(951) 358-5198

San Bernardino County Residents
San Bernardino County CCS Program
150 E. Holt Blvd, 3rd Floor
Ontario, CA 91761
Phone: (909) 458-1637
Fax: (909) 986-2970

Referral Must Be E-Mailed To:
CCSReferrals@DPH.SBCounty.gov

D. PCPs and/or referring Specialists are also responsible for notifying the IPA of Members referred to CCS. IPA Care Managers are responsible for facilitating referrals and tracking outcomes.

E. CCS sends a CCS program application and agreement to the Member, parent, or legal guardian. The PCP may assist with the completion of the forms.

F. CCS determines program eligibility by evaluating medical necessity and appropriateness of the requested service. All services require prior authorization by CCS. Criteria for eligibility include documentation of a CCS-eligible condition.

G. Once eligibility is established and the request for service is approved, CCS issues an authorization for treatment to a CCS-approved facility or paneled Provider.[4] (Please refer to the following link for up-to-date list of approved facilities and paneled Providers: http://www.dhcs.ca.gov/services/ccs/pages/CCSProviders.aspx.)

IEHP and IPA Responsibilities

[3] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 9, CCS
[4] Ibid.

~~C.~~B. California Children's Services

A. IPAs will have an established process which demonstrates the coordination of care between PCPs and Specialty Care Providers.

B. The IPA Care Manager follows all cases referred to CCS throughout the treatment process and assists with the coordination of care.

C. Medically necessary health care must continue to be provided throughout the referral process, and regardless of whether or the child is accepted into the CCS program.[5] The PCP and the Member's IPA are responsible for all medically necessary health care related to a potential CCS eligible condition until CCS establishes eligibility and issues a Service Authorization Request (SAR).[6] The IPA will be reimbursed should CCS determine upon later review that Member qualified for the program. The CCS program is only responsible for treatment and payment for CCS services that treat CCS eligible conditions.

D. The IPA Care Manager must assist the PCP in coordinating available services and providing follow-up for Members requiring referral to CCS through the following methods:

   1. Provision of telephonic monitoring of Members potentially eligible for the CCS program;
   2. Maintenance of communication and coordination with County CCS Case Managers;
   3. Coordination with the PCP to ensure that medically necessary health care services are provided for conditions not eligible for the CCS program or when CCS denies authorization for any services;[7] and
   4. Establishing lines of communication between Practitioners.

E. PCPs and IPAs continue to be responsible for other medically necessary care,[8] including certain Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services as discussed in Policy 12D, "Early and Period Screening, Diagnostic and Treatment (EPSDT)." CCS may authorize EPSDT services related to the CCS condition for Medi-Cal Members.

F. PCPs and IPAs can view a list of their CCS Members, their authorizations and diagnosis information by logging in to the secure IEHP Provider portal. IPAs are also provided this information through the Secure File Transfer Protocol (SFTP).

G. IEHP is available to assist the IPA with care management activities through the following methods:

   1. Identification of appropriate community referral sources available to Members;
   2. Provision of training on the CCS program including referral processes and methods to identify Members eligible for CCS program services; and

[5] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 9, CCS
[6] Ibid.
[7] Ibid.
[8] Ibid.

~~C.~~B. California Children's Services

3. Assistance with the facilitation of the link between the IPA CM and CCS Program staff, as needed.

~~C.~~B. California Children's Services

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12. COORDINATION OF CARE

C. Early Start Services and Referrals

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. Primary Care Providers (PCPs) and Specialists are responsible for assessing children's developmental status and identifying children who may be eligible for receiving Early Start services during Well Child exams, or at other medical encounters as appropriate.[1,2] This includes children with a condition known to lead to developmental delay, those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay.

B. PCPs and IPAs are responsible for providing primary care and/or arranging all medically necessary diagnostic, specialty, or therapeutic services to evaluate, correct and/or ameliorate a suspected or confirmed condition.[3]

DEFINITION:

A. Early Start Program – California's early intervention program for infants and toddlers with disabilities and their families.

PROCEDURES:

Early Start Program

A. Members from birth to 36 months of age may be eligible for early intervention services if, through documented evaluation and assessment, they meet one (1) of the criteria listed below:~~:~~[4,5]

   1. Has a developmental delay of at least 33% in one (1) or more areas of cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing;.

   2. Has an established risk condition of known etiology, with a high probability of resulting in delayed development>~~; or~~

   3. Is considered at high risk of having a substantial developmental disability due to a combination of biomedical risk factors of which are diagnosed by qualified personnel.

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 11, Early Intervention Services
[2] Title 17 California Code of Regulations (CCR), § 52040
[3] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 11, Early Intervention Services
[4] California Government Code (Gov. Code), § 95014(a)
[5] 17 CCR § 52022

B. Based on the child's assessed need(s) and in collaboration with the family, the Early Start Program develops the child's Individualized Family Service Plan (IFSP).[6] Services may include:[7]

1. Assistive technology;
2. Audiology;
3. Family training, counseling and home visits;
4. Health services;
5. Medical services for diagnostic/evaluation purposes only;
6. Nursing services;
7. Nutrition services;
8. Occupational therapy;
9. Physical therapy;
10. Psychological services;
11. Service coordination (Case Management);
12. Social work services;
13. Special instruction;
14. Speech and language services;
15. Transportation and related costs; or
16. Vision services.

For more information about services offered through Early Start Program, refer to the following website: https://www.dds.ca.gov/services/Early-Start/.

C. Newly referred families whose infants or toddlers are "at risk" for developmental delay or disability will receive the following services through the Early Start Family Resource Network (ESFRN) (additional details are available on their website at http://www.esfrn.org):

1. Information;
2. Resources;
3. Referrals; and
4. Targeted outreach.

[6] 17 CCR § 52104
[7] Title 20 United States Code (U.S.C) § 1432

Identification and Referral of Members

A. All Members from birth to 36 months of age, suspected of having a developmental concern, including those at risk for developmental delay,~~-~~ are referred to the Early Start program to determine eligibility for services.[8] Early Start will facilitate each family's access to local Family Resource Center's Prevention Resource and Referral Services with parental consent.

B. The Provider must perform the following to facilitate the referral to the Early Start Program, including first discussing their concerns with the family:

1. Regular well baby examinations according to the Child Health and Disability Program (CHDP) schedule (with specific findings noted);
2. Diagnostic and laboratory and radiological test results;
3. Routine developmental assessment using standardized developmental tools;
4. Evaluation of hearing and vision;
5. Explain developmental concerns to family;
6. Identify established risk conditions of known etiology, with a high probability of resulting in delayed development;
7. Obtain parental consent to send child's medical records to the Early Start Program;
8. Other medical referrals as appropriate;
9. Make referral as soon as possible to the Early Start Program;
10. Inform family of the Early Start referral and the importance of following up on child's development; and
11. Inform the IPA Care Management Team that the Member was referred to the Early Start Program.

C. Anyone can make a referral, including parents, medical care Providers, neighbors, family members, foster parents, and daycare providers ~~(see Attachment, "Inland Regional Center Early Start Program Referral Form" in Section 12)~~. The referral must be made by phone or by completing the online referral form ~~located on the IRC/Early Start website~~: https://inlandrc.seamlessdocs.com/f/esreferral~~:~~

Riverside County	**San Bernardino County**
Phone: (909) 890-4763	(909) 890-4711

D. The Early Start Program determines a child's eligibility and assessment of service needs.[9]

[8] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 11, Early Intervention Services

[9] "Parents' Rights: An Early Start Guide for Families", https://www.dds.ca.gov/wp-content/uploads/2019/02/EarlyStart_ProceduralSafeEng_20190205.pdf

Primary Care and Specialty Referrals

A. PCPs, with assistance from their IPA Utilization Management (UM)/CM staff as needed, are responsible for referring Members with suspected or confirmed developmental delay for all medically necessary specialty diagnostic and/or treatment services including but not limited to the following. See Policy 14D, "Pre-Service Referral Authorization Process," for more information.

1. Specialty diagnostic services to evaluate the Member's condition (e.g., computed tomography (CT) or magnetic resonance imaging (MRI) scans, etc.);
2. Specialists for diagnosis or treatment (e.g., Neurologists);
3. Referrals to Psychologists or Psychiatrists as needed;
4. Referral to other types of Providers as needed (e.g., Physical Therapy (PT), Occupational Therapy (OT)); and
5. All other specialty health care services as needed.

IEHP and IPA Responsibilities

A. The Member's IPA is responsible for coordinating all medically necessary specialty care including:

1. In-network diagnostic, therapeutic or specialty services;
2. Out-of-network services as needed; and
3. Referral and coordination of services rendered under Fee-For-Service Medi-Cal as needed, through California Children's Services (CCS), Behavioral Health, PCP, Specialists, or other Providers.

B. When a Member is receiving services from the Early Start Program, the IPA CM is responsible for ensuring that medical and health assessment information is provided to the Early Start Program, as needed. IPA CM's responsibility for arranging all necessary transfer of medical information includes but is not limited to:

1. Facilitating PCP or specialist telephonic communication with the Early Start Program or Local Education Agency (LEA) staff as needed;
2. Transferring medical records, diagnostic test results or other hard copy medical information as needed; and
3. Arranging case conferences with PCP, Specialist and Early Start Program or LEA staff as needed.

For more information about services offered by the Regional Center, refer to the following website: https://www.dds.ca.gov/RC/.

C. Member rosters indicating Early Start eligibility are updated monthly on the secure IEHP Provider portal. IPAs ensure the coordination of care and services and joint case management between their PCPs and Early Start.

D. IEHP sends the IPA a monthly list of Members who will be aging out of the Early Start Program within the next three (3) months. The IPA is required to evaluate and assess the Member to determine if additional care coordination is needed as they transition out of the Early Start Program. This information is shared with the IPA via the IEHP's Secure File Transfer Protocol (SFTP).

E. IEHP Behavioral Health & Care Management (BH & CM) Department is responsible for the following functions:

1. Facilitating working relationships between IPAs and the Regional Center as needed;
2. Assisting IPA CM with referrals to the Early Start Program, care coordination or care management as needed;
3. Resolving any disputes between the Regional Center, PCP/Specialists and/or IPA;
4. Attend Regional Center meetings, as necessary;
5. Arranging appropriate training for PCP and IPA staff regarding the Early Start Program; and
6. Other assistance as required.

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12. COORDINATION OF CARE

D. Early and Periodic Screening, Diagnostic and Treatment

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members under the age of 21.

POLICY:

A. IEHP and its IPAs provide and cover all medically necessary Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for Members under 21 years of age, when services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions, unless otherwise carved out of the Plan's contract with the Department of Health Care Services (DHCS).[1,2]

1. A service does not need to cure a condition in order to be covered under EPSDT.
2. Services that maintain or improve the ~~child's~~~~smemnber's~~Member's current health condition, or those that can prevent adverse health outcomes, are also covered under EPSDT because they 'ameliorate' a condition.[3]

PURPOSE:

A. To assure that children receive early detection and care so that health problems are averted or diagnosed and treated as early as possible.[4]

DEFINITION:

A. EPSDT Services – a benefit of the State's Medi-Cal program that provides comprehensive, preventive, diagnostic, and treatment services to eligible children under the age of 21.[5] This is otherwise known as "Medi-Cal for Kids & Teens."

B. Care Coordination – Coordination of services for a Member between settings of care that includes appropriate discharge planning for short-term and long-term hospital and institutional stays, and appropriate follow up after an emergency room visit; services the Member receives from any other MCP; services the Member receives in Fee-for-Service (FFS); services the Member receives from out-of-network Providers; and services the Member receives from community and social support Providers.[6]

~~B.~~C. Case Management ~~– Services –~~ Services furnished to assist Members who reside in a

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 5, Services for Members under Twenty-One (21) Years of Age
[2] DHCS All Plan Letter (APL) ~~19-010~~23-005 Supersedes APL ~~18-007 and 07-008~~19-010, "Requirements for Coverage of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services for Medi-Cal Members Under the Age of 21"
[3] Ibid.
[4] Centers for Medicare and Medicaid Services (CMS), A Guide for States: Coverage in Medicaid Benefit for Children and Adolescents, June 2014
[5] Title 42 United States Code (USC) §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), and 1396d(r)
[6] DHCS APL 23-005

community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services.[7,8,9,10]

~~C.~~D. Medical Necessity for EPSDT Services – For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity," when the service is necessary to correct or ameliorate defects and physical and mental illnesses and conditions ~~that are discovered by screening services~~.[11,12]

~~D.~~E. Maintenance services – Services that sustain or support rather than those that cure or improve health problems.[13]

~~E.~~F. Targeted Case Management (TCM) – Services which assist Members within specified target groups to gain access to needed medical, social, educational, and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors.[14]

~~F.~~G. Home Health Agency – A public or private organization licensed by the State which provides skilled nursing services to persons in their place of residence.[15]

~~G.~~H. Individual Nurse Provider (INP) – Medi-Cal enrolled Licensed Vocational Nurse or Registered Nurse who independently provides Private Duty Nursing services in the home to Members.

~~H.~~I. Private Duty Nursing (PDN) – Nursing services provided in a Member's home by a registered nurse or a licensed practical nurse, under the direction of a Member's physician, to a Member who requires more individual and continuous care than is available from a visiting nurse.[16]

PROCEDURES:

EPSDT Services

A. All Members under the age of 21 must receive EPSDT preventive services, including screenings, designed to identify health and developmental issues as early as possible. IEHP, its IPAs and Providers must provide its Members with appropriate referrals for diagnosis and treatment without delay. IEHP and its IPAs must ~~are required to provide care coordination to~~ ensure that Members have timely access to all medically necessary ~~EPSDT~~ services~~.~~ and that ~~A~~appropriate diagnostic and treatment services ~~must be~~are initiated ~~within established access standards~~as soon as possible, but not later than ~~sixty (60)~~ calendar days following either a

[7] Title 42 Code of Federal Regulations (CFR) §§ 440.169 and 441.18
[8] 42 CFR 440.169(d) and (e)
[9] Title 22 California Code of Regulations (CCR) § 51184
[10] I.N. et al., v. Kent, et al. (Northern District of California 2018)
[11] California Welfare and Institutions Code (Welf. & Inst. Code) § 14095.5
[12] 42 USC § 1396d(r)
[13] DHCS APL ~~19-010~~23-005
[14] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 1, Definitions
[15] California Health and Safety Code (Health & Saf. Code), § 1727(a) and (b)
[16] 42 CFR § 440.80

preventive screening or other visit that identifies a need for follow-up.[17] See Policy 14D, "Pre-Service Referral Authorization Process" for further details regarding the referral process.

~~A. Authorization and financial responsibilities for EPSDT services are delineated in the Division of Financial Responsibility (DOFR).~~

B. ~~IEHP requires its contracted~~ Primary Care Providers (PCPs) ~~to provide initial and periodic health assessments in accordance with the Recommendations for Preventive Pediatric Health Care that is based on the consensus statement from the~~ must use current American Academy of Pediatrics (AAP) and Bright Futures periodicity schedule and guidelines when delivering care to any Member under the age of 21, including but not limited to health and developmental screening services, physical examination, dental services, vision services, and hearing services. PCPs must provide all age-specific assessments and services required by DHCS and the AAP/Bright Futures periodicity schedule. This, however, does not alleviate IEHP or its IPAs from their responsibility to provide any medically necessary EPSDT services that exceed those recommended by AAP/Bright Futures.[18,19] Please see Policy 10C1, "Pediatric Preventive Services – Well Child Visits" for more information.

C. IEHP and its IPAs are responsible for providing all medically necessary EPSDT services, including services which exceed the amount provided by Local Education Agencies (LEAs), Regional Centers (RCs), or local governmental health programs (LGHPs).

1. Where any of these entities has overlapping responsibility for providing services to a Member under the age of 21, the IPA must:[20]

   a. Assess what level of medically necessary EPSDT services the Member requires;

   b. Determine what level of service (if any) is being provided by other entities, and

   c. Coordinate the provision of services with the other entities to ensure that the IPA and other entities are not providing duplicative services, and that the child is receiving all medically necessary EPSDT services in a timely manner.

~~Authorization and financial responsibilities for EPSDT services are delineated in the Division of Financial Responsibility (DOFR).~~

2. Neither IEHP nor its IPAs impose flat or hard limits on ~~service limitations on any~~ EPSDT ~~benefit~~ services based on a monetary cap or budgetary constraints.~~other than medical necessity, as defined in this policy~~.

3. Medical necessity decisions are based on the definition set forth in this policy and individualized, considering the particular needs of the child. When medically necessary, neither IEHP or its IPAs impose limits on EPSDT services and cover services whether or not these have been approved under a State Plan Amendment (SPA).~~The determination~~

[17] DHCS APL 23-005
[18] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 5, Services for Members Under Twenty-One (21) Years of Age
[19] DHCS APL ~~19-010~~23-005
[20] Ibid.

~~of whether a service is medically necessary for an individual child is made on a case-by-case basis, considering the particular needs of the child.~~[21]

4. IEHP prior authorization criteria must either be the same, or must not be more restrictive, than the criteria for approval set forth in the regulations established from the Medi-Cal Fee-For-Service.

5. Determinations must be made in a timely manner, not to exceed regulatory turnaround timeframes for determination and notification of Members and Practitioners.[22] See Policy 25E1, "Utilization Management - Delegation and Monitoring" for more information.

6. IEHP and its IPAs ensure IEHP Members with pre-existing provider relationships who make a Continuity of Care (COC) request are given the option to continue treatment for up to twelve (12) months with an out-of-network Medi-Cal provider. These eligible Members may require COC for services they have been receiving through Medi-Cal Fee-For-Service (FFS) or another health plan.[23] See Policy 12A2, "Care Management Requirements – Continuity of Care" for more information.

7. Services must be provided in the most integrated setting appropriate to Members and in compliance with anti-discrimination laws.[24]

~~C.~~A. ~~IEHP informs Members or their families or primary caregivers through the Member Handbook about EPSDT, including the benefits of preventive care, the services available under EPSDT, where and how to obtain these services, and that necessary transportation and scheduling assistance is available. IEHP also provides this information on an annual basis to Members under the age of 21 or their families/primary caregivers, who have not accessed EPSDT services.~~[25]

~~D.~~A. ~~IEHP and its IPAs are responsible for assessing a Member's need for EPSDT care management services.~~

~~E.~~A. ~~IEHP and its IPAs are responsible for providing all medically necessary EPSDT services, including services which exceed the amount provided by Local Education Agencies (LEAs), Regional Centers (RCs), or local governmental health programs (LGHPs). Where any of these entities has overlapping responsibility for providing services to a Member under the age of 21, the IPA must:~~[26]

~~1. Assess what level of medically necessary EPSDT services the Member requires;~~

~~2.~~1. ~~Determine what level of service (if any) is being provided by other entities, and~~

[21] Ibid.
[22] 42 CFR §§ 438.210, 422.568, 422.570, and 422.572
[23] DHCS APL 22-032 Supersedes APL 18-008, "Continuity of Care for Medi-Cal Members Who Transition Into Medi-Cal Managed Care from Medi-Cal Fee-for-Service, and for Medi-Cal Members Who Transition Into A New Medi-Cal Managed Care Health Plan on or After January 1, 2023"
[24] California Government Code § 11135
[25] ~~Ibid.~~
[26] ~~DHCS BAPL 19-010~~

~~3.1. Coordinate the provision of services with the other entities to ensure that the IPA and other entities are not providing duplicative services, and that the child is receiving all medically necessary EPSDT services in a timely manner.~~

D. Some medical or behavioral health care service for a Member under age 21 may not be covered as IEHP benefits but may be available as EPSDT services, as medically necessary.

E. IEHP ensures that Subcontractors and Network Providers comply with all applicable state and federal regulatory requirements, including requirements for EPSDT.[27]

~~F.~~

~~Referral for EPSDT Services~~

~~A. IEHP, its IPAs and Providers are required to provide care coordination to ensure that Members have timely access to all medically necessary EPSDT services. Appropriate diagnostic and treatment services must be initiated within established access standards but not later than sixty (60) calendar days following either a preventive screening or other visit that identifies a need for follow-up.[28] See Policy 14D, "Pre-Service Referral Authorization Process" for further details regarding the referral process.~~

~~B.~~A. ~~Neither IEHP nor its IPAs impose service limitations on any EPSDT benefit other than medical necessity, as defined in this policy. The determination of whether a service is medically necessary for an individual child is made on a case-by-case basis, considering the particular needs of the child.[29]~~

~~C.~~A. ~~Determinations must be made in a timely manner, not to exceed regulatory turnaround timeframes for determination and notification of Members and Practitioners.[30] See Policy 25E1, "Utilization Management - Delegation and Monitoring" for more information.~~

~~D.~~A. ~~IEHP and its IPAs ensure IEHP Members with pre-existing provider relationships who make a Continuity of Care (COC) request are given the option to continue treatment for up to twelve (12) months with an out-of-network Medi-Cal provider. These eligible Members may require COC for services they have been receiving through Medi-Cal Fee-For-Service (FFS) or another health plan.[31] See Policy 12A2, "Care Management Requirements – Continuity of Care" for more information.~~

~~E.~~A. ~~IEHP prior authorization criteria must either be the same, or must not be more restrictive, than the criteria for approval set forth in the regulations established from the Medi-Cal Fee-For-Service.~~

Member Outreach and Network Provider Training

A. IEHP ~~informs~~provides Members or their families or primary caregivers ~~through the Member~~

[27] DHCS APL 23-005
[28] ~~Ibid.~~
[29] ~~Ibid.~~
[30] ~~42 CFR §§ 438.210, 422.568, 422.570, and 422.572~~
[31] ~~DHCS APL 18-008 Supersedes APL 15-019, "Continuity of Care for Medi-Cal Members Who Transition Into Medi-Cal Managed Care"~~

~~Handbook~~information about EPSDT, including the benefits of preventive care, the services available under EPSDT, where and how to obtain these services, and that necessary transportation and scheduling assistance is available. Information is shared as follows:[32]

1. Beginning 2023, IEHP will mail with their post-enrollment kit DHCS-developed "Medi-Cal for Kids & Teens" brochures and "Medi-Cal for Kids & Teens: Your Medi-Cal Rights" letter to new Members under the age of 21, or their families or primary caregivers within seven (7) calendar days of their enrollment with IEHP.
2. On January 1st of each calendar year, beginning in 2024, IEHP will mail or share electronically these DHCS-supplied materials to existing ~~IEHP also provides this information on an annual basis to~~ Members under the age of 21 or their families/primary caregivers~~, who have not accessed EPSDT services~~.[33]
3. Information provided meets all language and accessibility standards, including translation, font, and format requirements set forth in federal and state law, the Plan's contract with DHCS, and applicable DHCS All Plan Letters.
4. All member-facing materials are updated as needed with "Medi-Cal for Kids & Teens."
5. IEHP publishes DHCS-supplied materials and "Medi-Cal for Kids and Teens: Your Medi-Cal Rights" letter on the website.

B. Beginning in 2024, IEHP will ensure all Network Providers complete EPSDT-specific training on at least a biannual basis.

C. On an annual basis by February 15 of each calendar year, IEHP will submit to DHCS a comprehensive plan to ensure all Network Providers received proper education and training regarding EPSDT. The annual comprehensive plan will include an attestation that Provider Network is in compliance with EPSDT training requirements and includes a list of Network Providers who have completed training within the past 12 months. The annual comprehensive plan will also include the following:[34]

1. How many Network Providers serve Members under the age of 21;
2. How many Network Providers are not in compliance, and;
3. IEHP's steps taken to ensure Network Providers are fully compliant.

D. IEHP will use the Provider training program developed by DHCS to promote a more uniform and shared understanding of the benefit throughout the State. If IEHP chooses to augment the training with additional information, IEHP will submit their training materials with edits highlighted to DHCS for review and approval prior to its use.

Private Duty Nursing

A. IEHP is responsible for authorizing and covering medically necessary private duty nursing

[32] Ibid.
[33] ~~Ibid.~~
[34] DHCS APL 23-005

services for Members under the age of 21. If an IPA receives a request for these services, the IPA shall forward this request to IEHP Utilization Management via fax at (909) 890-5751.

B. Private duty nursing services are covered when they meet the medical necessity criteria. Below are examples of when these services may be deemed appropriate:

1. The Member for whom nursing care is requested meets any of the criteria of admission to licensed and certified health facility inpatient care settings, and his/her medical condition has stabilized such that care can safely be rendered in the home;
2. The Member is newly discharged from an acute or sub-acute inpatient setting and is dependent upon a life-sustaining medical technology, and his/her medical condition has stabilized such that care can safely be rendered in the home;
3. There is a primary caregiver in the home that is proficient in the tasks necessary to care for the Member; and
4. An assessment of the home environment has been conducted by a qualified home health agency or other appropriate person. The assessment must verify that an attending physician accepts twenty-four (24) hour responsibility for providing and coordinating medical care; the home environment supports the health and safety of the Member; that space is adequate to accommodate needed equipment, supplies, and personnel; the family caregivers have been appropriately trained; and all necessary supports and an emergency back-up plan are in place.

C. IEHP uses one or more home health agencies (HHAs) and/or individual nurse providers (INPs) to meet the Member's approved private duty nursing needs.[35] IEHP identifies potentially eligible HHAs and/or INPs and assists them with navigating the process of enrolling as Medi-Cal Providers.[36]

D. When IEHP has approved an EPSDT eligible Member to receive private duty nursing services, the Plan has primary responsibility to provide case management for approved private duty nursing services.[37,38]

E. Regardless of which Medi-Cal program entity has primary responsibility for providing case management for the approved private duty nursing services, an EPSDT eligible Member approved to receive private duty nursing services, and/or their personal representative, may contact any Medi-Cal program entity that the Member is enrolled in (which may be a Managed Care Plan or CCS) to request case management for private duty nursing services.[39] If contacted by the Member, IEHP will provide case management services to the Member and work collaboratively with the Medi-Cal program entity primarily responsible for case

[35] DHCS APL 20-012, "Private Duty Nursing Case Management Responsibilities For Medi-Cal Eligible Members Under The Age Of 21"
[36] DHCS APL 20-012~~Ibid.~~
[37] I.N. et al., v. Kent, et al. (N.D. Cal 2018)
[38] DHCS APL 20-012
[39] Ibid.

management.[40]

F. ~~IEHP is required to provide case management services as set forth in its Medi-Cal contract to all Medi-Cal Members who are EPSDT eligible and for whom Medi-Cal private duty nursing services have been approved, including, upon a plan Member's request.~~ Case management services includes arranging for all approved private duty nursing services desired by the Member, even when IEHP is not financially responsible for paying for the approved private duty nursing services.[41]

G. IEHP's obligations to EPSDT eligible Members approved to receive private duty nursing services who request case management services for their approved private duty nursing services include, but are not limited to:[42]

1. Providing the Member with information about the number of private duty nursing hours the Member is approved to receive;
2. Contacting enrolled HHAs and Medi-Cal enrolled INPs to seek approved private duty nursing services on the Member's behalf;
3. Identifying and assisting potentially eligible HHAs and INPs with navigating the process of enrolling to be a Provider; and
4. Working with HHAs and Medi-Cal enrolled INPs to jointly provide private duty nursing services to the Member as needed.

Behavioral Health Treatment Services

A. IEHP is responsible for providing and managing medically necessary Behavioral Health Treatment (BHT) services for all Members that meet all the following coverage criteria:[43]

1. Member is under 21 years of age;
2. Member was recommended by a licensed physician and surgeon or a licensed psychologist that evidence based BHT services are medically necessary;
3. Member is medically stable; and
4. Member does not need 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).

Please see Policy 12K3, "Behavioral Health – Behavioral Health Treatment" for more information on the authorization and management of BHT services.

Carved-Out Services

A. IEHP and its IPAs provide and cover all medically necessary EPSDT services except those services that are specifically carved out of IEHP's contract and not included in IEHP's

[40] I.N. et al., v. Kent, et al. (N.D. Cal 2018)
[41] Ibid.
[42] DHCS APL 20-012
[43] DHCS APL 19-014 Supersedes APL 18-006, "Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21"

capitated rate, ~~such as~~which includes but is not limited to California Children's Services (CCS), pharmacy services, ~~and~~ dental services, specialty mental health services, and substance use disorder services.[44]

1. CCS - Once the IPA has adequate diagnostic evidence that a Member has a CCS-eligible condition, the IPA must refer the Member to the local county CCS office for determination of eligibility. Until the Member's CCS eligibility is confirmed by the local CCS program, and the medically services are being provided under the CCS program, the IPA remains responsible for the provision of all medically necessary EPSDT services. Once member is deemed eligible for CCS, ~~and~~ CCS becomes responsible for case management and care coordination. Please see Policy 12B, "California's Children's Services" for more information.

2. Dental Services – IEHP ensures that dental screenings and oral health assessments for all Members are included as part of the initial health ~~assessment~~appointment. Please see Policy 10C1, "Pediatric Preventive Services – Well Child Visits," for more information on dental screening for Members under 21 years of age. IEHP covers and ensures the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists but may require prior authorization for medical services required in support of dental procedures.[45] Please see Policy 12J, "Dental Services" for more information.

Care Management and Care Coordination

A. IEHP and its IPAs are responsible for assessing a Member's need for EPSDT care management services.

~~A.~~ IEHP and its IPAs provide ~~comprehensive medical~~ case management ~~services~~ and care coordination, as defined in this policy, for ~~all~~ medically necessary EPSDT services~~for Members under the age of 21~~,[46] including but not limited to:

~~1. *Performing a comprehensive assessment and periodic reassessment of individual need, to determine the need for any medical, educational, social or other services;*[47]~~

~~2. *Developing and periodically updating a specific care plan based on the information collected through the assessment, which includes:*~~

~~a. *Goals and actions to address the medical, social, educational and other service needs of the Member;*~~

~~b. *Ensuring active participation by the Member in developing their goals; and*~~

~~c.~~B. ~~*Identifying a course of action to respond to the assessed needs of the Member;*~~

~~3.~~1. Helping ensure that the Member obtains needed services through the following:

a. Coordinating ~~all~~ medically necessary EPSDT services delivered both within and

[44] DHCS APL ~~19-010~~23-005
[45] DHCS APL 15-012, "Dental Services – Intravenous Sedation and General Anesthesia Coverage"
[46] ~~DHCS APL 19-010~~
[47] ~~42 CFR § 440.169(d)~~

outside the network;

b. Coordinating carved-out and linked service and referral to appropriate community resources and other agencies, regardless of whether IEHP is responsible for paying for the service;[48]

c. Providing assistance with scheduling appointments;[49]

d. Coordinating the Member's care between all Providers (PCPs, Specialists, other EPSDT Providers); and

e. Facilitating the transfer of medical information as necessary between Providers.

~~4. Monitoring and following up to ensure that the care plan is effectively implemented and adequately addresses the needs of the Member.~~

~~B.~~C. IEHP provides necessary transportation, including non-emergency medical transportation (NEMT) and non-medical transportation (NMT) to and from medical appointments for the medically necessary EPSDT services, including those services that are carved-out of the Plan's contract with DHCS.[50] See Policy 9C, "Non-Emergency Medical and Non-Medical Transportation Services" for more information.

~~C.~~A. ~~When IEHP has approved an EPSDT eligible Member to receive private duty nursing services, the Plan has primary responsibility to provide case management for approved private duty nursing services.[51][52]~~

~~D.~~A. ~~Regardless of which Medi-Cal program entity has primary responsibility for providing case management for the approved private duty nursing services, an EPSDT eligible Member approved to receive private duty nursing services, and/or their personal representative, may contact any Medi-Cal program entity that the Member is enrolled in (which may be a Managed Care Plan or CCS) to request case management for private duty nursing services.[53] If contacted by the Member, IEHP will provide case management services to the Member and work collaboratively with the Medi-Cal program entity primarily responsible for case management.[54]~~

~~E.~~A. ~~IEHP is required to provide case management services as set forth in its Medi-Cal contract to all Medi-Cal Members who are EPSDT eligible and for whom Medi-Cal private duty nursing services have been approved, including, upon a plan Member's request. Case management services includes arranging for all approved private duty nursing services desired by the Member, even when IEHP is not financially responsible for paying for the approved private~~

[48] DHCS APL ~~19-010~~23-005
[49] Ibid.
[50] ~~Ibid.~~Ibid.
[51] ~~I.N. et al., v. Kent, et al. (N.D. Cal 2018)~~
[52] ~~DHCS APL 20-012~~
[53] ~~DHCS APL 20-012~~
[54] ~~I.N. et al., v. Kent, et al. (N.D. Cal 2018)~~

duty nursing services.[55]

F.A. IEHP's obligations to EPSDT eligible Members approved to receive private duty nursing services who request case management services for their approved private duty nursing services include, but are not limited to:[56]

1. Providing the Member with information about the number of private duty nursing hours the Member is approved to receive;

2.1. Contacting enrolled HHAs and Medi-Cal enrolled INPs to seek approved private duty nursing services on the Member's behalf;

3.1. Identifying and assisting potentially eligible HHAs and INPs with navigating the process of enrolling to be a Provider; and

4.1. Working with HHAs and Medi-Cal enrolled INPs to jointly provide private duty nursing services to the Member as needed.

IEHP ensures coverage of Targeted Case Management (TCM) services,[57] which may be provided by a TCM entity (e.g.,such as the Inland Regional Center or local governmental health program), a child protection agency, other government agencies or entities serving children, or an individual practitioner whom the IPA (in consultation with IEHP) finds qualified by education, training, or experience to provide specialized care management services. *in Riverside County.*[58]. –*TCM services provides comprehensive case management services to eligible Members under the age of 21 to gain access to needed medical, social, educational, and other services. Case management services ensure that the changing needs of Members are addressed and that appropriate TCM services components are provided to meet the Member's needs.*

TCM services include the following[59]:

Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services.

Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment.

Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services.

Monitoring and follow-up activities

[55] I.N. et al., v. Kent, et al. (N.D. Cal 2018)
[56] DHCS APL 20-012
[57] Ibid.DHCS APL 19-010
[58] Department of Health Care Services (DHCS) California State Plan Amendments (SPA) 21-0022, "Children Under the Age of 21"
[59] Department of Health Care Services (DHCS) Medi-Cal Targeted Case Management Provider Manual, "TCM Program Overview"

D. Eligible Members must be:[60] ~~:~~

1. At high risk for medical compromise due to one (1) of the following conditions:
   a. Failure to take advantage of necessary health care services~~,~~; ~~or~~
   b. Noncompliance with their prescribed medical regimen~~n,~~; ~~or~~
   c. ~~An inability~~Unable to coordinate multiple medical, social, and other services due to the existence of an unstable medical condition in need of stabilization~~,~~; ~~or~~
   d. ~~An inability~~Unable to understand medical directions because of comprehension barriers~~,~~; ~~or~~
   e. A lack of community support system to assist in appropriate follow-up care at home;
   f. Substance abuse~~,~~; or
   g. A victim of abuse, neglect or violence~~:~~.
2. In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

~~G.~~

E. Upon identification of an eligible Member, IPAS are responsible for referring Members directly to a TCM entity, such as the Regional Center (RC) or local governmental health program.

F. IPAs must coordinate ~~EPSDT requests~~ with IEHP to determine if the Member is eligible or is already receiving ~~targeted case management~~TCM through a participating local governmental ~~agency~~ health program or ~~through an entity or organization such as~~the R~~C~~egional ~~Center (RC)~~.

~~H.~~

~~I.~~ If the Member ~~receives targeted case management~~is receiving TCM through one of these entities, IEHP ~~and~~ or its IPAs will coordinate care with the case manager from the agency and ~~coordinate~~ determination of medical necessity of diagnostic and treatment services.[61]

G.

~~J.~~H. If ~~a~~ the Member is not ~~accepted~~ eligible for TCM services, IEHP ~~and~~ or its IPAs will ensure the Member has access to services that are comparable to TCM services.[62]

~~K.~~I. EPSDT care management services may be provided by IEHP and its IPAs, RC, Child Protective Services, ~~or~~ the Department of Mental Health, and/or other community~~-~~based entities as needed. See below for a list of contacts:

Inland Regional Center

[60] ~~DHCS SPA 21-0022~~Ibid.
[61] DHCS APL 23-005~~Ibid.~~
[62] ~~DHCS APL19-010~~Ibid.

San Bernardino Office:
1365 S. Waterman
San Bernardino, CA 92408
(909) 890-3000

Mailing address:
PO Box 19037
San Bernardino, CA 92423

Riverside Office:
1500 Iowa Avenue, Suite 100
Riverside, CA 92507
(909) 890-3000

https://www.inlandrc.org/

Children's Protective Services

Riverside County – Department of Public Social Services
(800) 442-4918 (Hotline)

San Bernardino County – Children and Family Services
(909) 384-9233
(800) 827-8724

Mental Health Program – Children's Coordination

Riverside County Mental Health (http://www.rcdmh.org)
Managed Care Office
4060A County Circle Dr
Riverside, CA 92503
Ph: (951) 358-7797

San Bernardino County Behavioral Health (http://www.sbcounty.gov/dbh)
850 E. Foothill Blvd.
Rialto, CA 92375
Ph: (909) 421-9200
Fax: (909) 421-9219

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revision Date:**	~~January~~ March 16, 2023

12. COORDINATION OF CARE

E. Genetically Handicapped Persons Program

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members.

POLICY:

A. The Genetically Handicapped Persons Program (GHPP) is a health care program which provides medical care and other related services for persons with genetically handicapping conditions.[1] GHPP will cover services only if they are not covered by IEHP. The program applies to adults with specific GHPP eligible conditions.

B. GHPP helps each client achieve the highest level of health and functioning through:[2]

1. Early identification and enrollment into the GHPP for persons with eligible conditions.
2. Prevention and treatment services from highly skilled Special Care Center teams.
3. Ongoing care in the home community provided by qualified physicians and other health team members.

PROCEDURES:

GHPP Services

A. GHPP services Members with specific genetic diseases. Conditions may include but are not limited to the following:[3]

1. Cystic fibrosis;[4]
2. Diseases of the Blood, i.e., Hemophilia, Von Willebrand's Disease, Sickle Cell Disease;[5]
3. Diseases of the Brain and Nerves, i.e. Huntington's disease, Hereditary Spastic Paraplegia;[6]
4. Diseases of Metabolism, i.e., Phenylketonuria (PKU), Wilson's Disease, Galactosemia;[7] and
5. Von Hippel-Lindau Disease.

For the most current overview of GHPP medical eligibility information, refer to the following website at: http://www.dhcs.ca.gov/services/ghpp/Pages/MedicalEligibility.aspx

[1] Title 17 California Code of Regulations (CCR) § 2930
[2] Ibid.
[3] California Health and Safety Code (Health & Saf. Code) § 125130
[4] 17 CCR § 2932
[5] Ibid.
[6] Ibid.
[7] Ibid.

B. GHPP offers the following program components:[8]

1. Medical and dental services provided in inpatient and outpatient settings including surgical and reconstructive services, home health, medications, vitamins, food supplements, blood products and oxygen;
2. Physical, occupational and speech therapy;
3. Prosthetic and orthopedic appliances and other durable medical equipment; and
4. Psychosocial services and respite care.

C. GHPP provides services at approved Special Care Centers (SCC). The GHPP Special Care Centers are a system that:[9]

1. Provides coordinated care to clients with specific genetic conditions;
2. Multi-disciplinary and multi-specialty teams which consists of doctors, nurses, social workers, and other health team members;
3. Provides family centered planning; and
4. Facilitates timely and appropriate care.

D. The GHPP SCCs are located throughout California and usually connected with tertiary level medical centers. Each SCC must comply with the GHPP program standards to become an approved provider.

Identification and Referral of GHPP Cases

A. Primary Care Providers (PCPs), Specialists and IPAs are responsible for the identification of Members with potentially eligible conditions and subsequent referral of those adults to the GHPP.

B. Once approved, GHPP provides authorization and payment for medical and non-medical services to adult Members with conditions eligible for treatment under the GHPP guidelines.

C. Application~~s~~ ~~www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/dhcs4000ab.pdf~~ and all supporting documentation may be submitted to GHPP in one of the three (3) following ways (see Attachment, "GHPP Application to Determine Eligibility" in Section 12):

Email: GHPPEligibility@dhcs.ca.gov;
Fax: 916-440-5762; or
Mail: Genetically Handicapped Persons Program
Integrated Systems of Care Division
~~311 S. Spring Street, Suite 800~~
~~Los Angeles, CA 90013~~MS 4502

[8] https://www.dhcs.ca.gov/services/ghpp/Pages/Benefits.aspx.
[9] Ibid.

P.O. Box 997413
Sacramento, CA 95899-7413

D. Medi-Cal Members may apply for GHPP benefits. Once the Member is enrolled in the program, they will receive the same services they are receiving from Medi-Cal in addition to the services available through the GHPP, such as Special Care Center services. Once the Medi-Cal clients are enrolled into this program, GHPP will case manage their GHPP-eligible conditions. PCPs are responsible for continuing all medically necessary health care other than the GHPP eligible condition.

IPA and Provider Responsibilities

A. GHPP is only responsible for treatment and payment for GHPP eligible conditions that are not a covered by ~~the~~IEHP or the Member's IPA. PCPs, IPAs and IEHP continue to provide for all other medically necessary care without interruption while pending GHPP determination. Financial and authorization responsibilities are delineated in the Division of Financial Responsibility (DOFR).

B. The IPA must follow all GHPP referred cases throughout the treatment process and assist with coordination and continuity of care, including but not limited to facilitating referrals and tracking outcomes. GHPP is responsible for the care management of GHPP eligible conditions.

C. IEHP is available to assist the IPA Care Manager with care coordination activities through the following methods:

1. Identification of appropriate community referral sources available to Members; or
2. Facilitating GHPP referrals if assistance is needed.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, ~~2022~~2023

12. COORDINATION OF CARE

F. In-Home Supportive Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members eligible for In-Home Supportive Services (IHSS).

POLICY:

A. Long-Term Services and Supports (LTSS) includes a wide variety of services and supports that help eligible Members meet their daily needs for assistance and improve the quality of their lives. IHSS is an LTSS that is provided over an extended period, predominantly in the Member's home and community.

B. IEHP covers In-Home Supportive Services (IHSS) in accordance with the eligibility determination performed by the County IHSS office. IHSS is a county-administered program with a foundation in consumer self-direction of care.[1,2,3]

PROCEDURES:

IHSS Eligibility Criteria

A. IEHP and its IPAs coordinate care and ensure referral to IHSS of Members who meet the eligibility criteria of being aged, blind or disabled persons who are unable to perform activities of daily living (ADLs) and cannot remain safely in their own homes without help.[4] In addition, Members requesting IHSS must meet these following eligibility criteria:[5]

1. Live at home or a home of Member's own choosing; and
2. At risk of institutionalization in long-term care facility.

B. An IHSS Member may be eligible to a maximum of two hundred eighty-three (283) hours per month.[6,7]

Identification and Referral of IHSS Cases

A. IEHP and its IPAs proactively identify Members with potential case management or IHSS program needs. Referral sources may include, but are not limited to the following:

1. IEHP and its IPAs;

[1] California Welfare and Institutions Code (Welf. & Inst. Code), § 12300
[2] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 21, Provision 7, Covered Services
[3] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 21, Provision 8, Coordination of Care
[4] CA Welf & Inst. Code, § 12300
[5] https://www.cdss.ca.gov/in-home-supportive-services
[6] CA Welf. & Inst. Code, § 12300
[7] CA Welf. & Inst. Code, § 14132.95

2. Interdisciplinary Care Team (ICT);
3. Health assessments (e.g., Health Risk Assessment);
4. Care plan intervention;
5. Internal IEHP departments (e.g., Behavioral Health & Care Management (BH & CM), Member Services ~~Department~~, Utilization Management, Provider Services, Pharmacy);
6. External Providers (e.g., Community-Based Adult Services (CBAS), Community-Based Organizations, Multipurpose Senior Services Program (MSSP), Independent Living Centers, Primary Care Providers (PCP), Hospitals, and Skilled Nursing Facilities);
7. Member and/or authorized representative; or
8. Member's caregiver.

B. IHSS accepts referrals from any entity including, but not limited to IEHP, IPAs, Hospital Care Managers, Providers, Members and/or their caregiver. Members who may benefit from IHSS are referred to the appropriate IHSS Central Intake Office.

1. Riverside County IHSS Hotline:
   a. Telephone number: (888) 960-4477
   b. Apply online at https://riversideihss.org/
2. San Bernardino County IHSS Hotline:
   a. Telephone number: (877) 800-4544
   b. Facsimile referral form: (909) 948-6560

C. The IHSS county agency is responsible for all assessments and reassessments associated with authorization of IHSS hours.[8,9,10] Based on the assessment findings, the County Social Worker determines IHSS hours and services. The County Social Worker will send the Notice of Action (NOA) to the Member following their service eligibility determination.[11] The NOA will describe Member's right to a State Fair Hearing process should the Member disagree with the number of determined hours or the denial of the IHSS request.

D. IHSS County Social Worker, PCP or IHSS Provider may request an interdisciplinary care team (ICT) case conference at any time to discuss the Member's needs by calling the IEHP Provider Relations Team at (909) 890-2054.

[8] CA Welf. & Inst. Code, § 14186
[9] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 21, Provision 3, Utilization Management
[10] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 21, Provision 3, Covered Services
[11] CA Welf. & Inst. Code § 12300.2

1. IEHP and its IPAs conduct ICT case conferences to coordinate the delivery of services and benefits as needed for each Member.
2. IEHP and its IPAs determine which Members need an ICT based on medical need, although every Member shall have access to an ICT, if requested.
3. Members can also request an ICT case conference at any time by calling IEHP Member Services at (800) 440-4347.

E. IEHP shares with the IPA through the secure IEHP Provider web portal, IHSS information, including IHSS hour allocations, as well as make this available to the Member's ICT.

~~E. If IEHP learns that a Member who is currently receiving IHSS has a condition that has changed, IEHP must advise the Member to contact the County IHSS Office to conduct an eligibility redetermination for IHSS.~~

Care Management

~~IEHP is responsible for authorizing medically necessary covered services and coordinating care for Members provided by IEHP's Network Providers, providing information necessary to assist Members or their authorized representatives in referring themselves to County for IHSS, and coordinating services and other related Medi-Cal LTSS provided by IEHP and other providers of carve-out programs, services, and benefits.~~

A. IEHP and its IPAs maintain the consumer-directed model for IHSS Members, which allows Members to self-direct their care by being able to hire, fire, and manage their caregivers.[12,13,14]

~~A.~~

B. The Member's IPA CM staff coordinate care and make referrals to IHSS county programs when needs are identified, such as Members who are at risk for out-of-home placement.[15] Care coordination adheres to a Member's determination about the appropriate involvement of his or her medical Providers and caregivers,[16] in accordance with the Health Insurance Portability and Accountability Act (HIPAA), which includes obtaining expressed consent from the Member or authorized representative to include the IHSS Provider in Member's care coordination planning.

C. It is the responsibility of the Member's PCP to complete the required IHSS Health Certification form. The PCP cannot charge or bill the Member for this service. See Policy

[12] CA Welf. & Inst. Code § 14186
[13] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 21, Provision 8, Coordination of Care
[14] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 21, Provision 7, Covered Services
[15] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 21, Provision 3, Utilization Management.
[16] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 21, Provision 8, Coordination of Care

18L, "Providers Charging Members." The Member's IPA assists Members in obtaining IHSS Health Care Certification Form SOC 873, if not submitted by Member in a timely manner.

D. Members are advised to call IHSS Public Authority to obtain emergency back-up services if their IHSS Provider does not arrive to provide assistance with authorized activities of daily living services:

1. Riverside County IHSS Public Authority: (800) 915-1777
2. San Bernardino County IHSS Public Authority: (866) 985-6322

Complaints, Grievances, and Appeals

A. IEHP Members have a right to register grievances and appeals with the State of California about the determination of authorized IHSS service hours by following the State Fair Hearing process.[17] Members are provided the following information:

1. The California Department of Social Services (CDSS) accepts formal complaint submissions in writing or by telephone.
   a. California Department of Social Services
      Public Inquiry and Response
      P.O. Box 944243, MS 9-17-37
      Sacramento, CA 94244-2430
   b. Phone 1-800-952-5253 (TDD 1-800-952-8349)
2. Members may also be directed to speak with a representative of their county Department of Public Social Services (for Riverside County residents) or the Department of Aging and Adult Services (for San Bernardino County residents) for assistance with the State Fair Hearing process.
3. IEHP does not adjudicate appeals from county decisions about IHSS services.
4. It is the responsibility of IEHP to report IHSS grievance resolutions to the state of California.[18]

IEHP complies with the established grievance and appeal process established by CDSS and by the county agencies responsible for IHSS.

5.

[17] CA Welf. & Inst. Code, §10950
[18] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 21, Provision 10, Required Reports for Managed Long-Term Services and Supports

IEHP Staff Training and Orientation Responsibilities

A. IEHP conducts annual trainings to educate health plan staff on IHSS as part of a LTSS option including:

   1. IHSS program overview;

   2. Referral Process;

   3. Eligibility and Assessment Criteria; and

   4. Program Services Available to Members.

B. IEHP trains IEHP personnel at least annually regarding the health plan's covered services and policies and procedures to access services and coordinate care.

C. IEHP trains personnel of IHSS organizations regarding IEHP's covered services and policies and procedures to access services and coordinate care.[19,20]

[19] Memorandum of Understanding (MOU) between IEHP and Riverside County In-Home Supportive Services Public Authority (PA)
[20] MOU between IEHP and San Bernardino County In-Home Supportive Services Public Authority (PA)

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Chief Title: Chief Medical Officer	**Revision Date:**	~~January 1, 2022~~November 14, 2023

12. COORDINATION OF CARE

G. Organ Transplant

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members and their living donors.

POLICY:

A. Effective January 1, 2022, IEHP covers all medically necessary adult and pediatric major organ transplants (MOTs) for eligible beneficiaries. IEHP will authorize, refer, and coordinate, the delivery of the MOT benefit and all medically necessary services associated with MOTs, including, but not limited to, pre-transplantation assessments and appointments, organ procurement costs, cadaver organ transplants, hospitalization, surgery, discharge planning, readmissions from complications for up to one (1) year post-transplant, post-operative services, dialysis, medications not otherwise covered by the MCP contract, transportation, and care coordination, including care and transportation for living donors. These services will be provided as outlined in the Medi-Cal Provider Manual, at facilities that have been designated as Medi-Cal Centers of Excellence (COEs) for the following transplants:[1]

1. Bone Marrow;
2. Heart;
3. Heart/Lung combined;
4. Combined Liver and Kidney
5. Liver /Intestinal;
6. Kidney;
7. Liver;
8. Intestinal;
9. Small Bowel;
10. Combined Liver and Small Bowel;
11. Lung;
12. Simultaneous Kidney and Pancreas;
13. Pancreas; and
14. Stem Cell.

B. IEHP covers medically necessary kidney, corneal, and autologous islet cell transplants from facilities that have been approved by Centers for Medicare and Medicaid Services (CMS) for

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 21-015 "Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative"

these types of transplants.[2]

PROCEDURES:

Provider Responsibilities

A. The Primary Care Provider (PCP) or Specialist is responsible for the initial diagnostic work-up prior to a referral to a Medi-Cal approved Transplant COE, California Children's Services (CCS) approved Special Care Center (SCC), or a CMS approved Organ Procurement and Transplantation Network (OTPN) member. During the initial diagnostic work-up, all prior authorizations for needed procedures or referrals to specialists, second surgical opinions, or hospital admissions must follow IEHP's prior authorization referral procedures.

IEHP and IPA Responsibilities

A. IEHP is responsible for the authorization and care of all medically necessary MOTs per the Division of Financial Responsibility (DOFR).

1. IEHP, in collaboration with the IPAs, is responsible for coordinating pre-work up, transplant surgery, and one (1) year of post-transplant care for all MOTs. This includes related care including but not limited to, dialysis, evaluation of potential donors, organ procurement, readmissions due to complications for one (1) year post-transplant, living donor care, and transportation services[3]. For more information about the transportation process, see Policy MC_09C "Non-Emergency Medical and Non-Medical Transportation Services."

    a. For beneficiaries under the age of 21 that are eligible for CCS, lodging and transportation services may be covered by the CCS Maintenance and Transportation (M&T) Benefit.[4]

2. IEHP is responsible for assisting the PCP or Specialist with all necessary diagnostic, therapeutic, or other specialty referrals for the Member being evaluated as a candidate for a possible organ transplant.

3. IEHP in collaboration with the IPAs, is responsible for assessing and approving, as appropriate, transplant services for Members who had an approved treatment authorization request (TAR) prior to January 1, 2022 but were not subsequently disenrolled from IEHP.[5]

4. IEHP Members may temporarily remain in FFS Medi-Cal for any of the following circumstances:[6]

    a. If they were temporarily disenrolled from IEHP in anticipation of receiving a MOT

[2]Ibid.
[3] DHCS APL 21-015
[4] Ibid.
[5] Ibid.
[6] Ibid.

and their approved TAR has expired (or is about to expire); or

b. If they have been enrolled with IEHP for ninety (90) days or less, and submit a medical exemption request (MER) that is approved by DHCS.

5. IEHP refers Members who meet medical necessity criteria for a specific major organ transplant to the appropriate transplant facility:[7]

   a. Members 21 years old and older are referred to a Medi-Cal Approved Transplant COE for an evaluation within 72 hours of the PCP or Specialist identifying the Member as a potential candidate for the MOT.

   b. Members under 21 years old are referred to the appropriate County CCS program for CCS eligibility determination within 72 hours of the PCP or Specialist identifying the Member as potential candidate for the MOT. IEHP will refer the Member to a CCS-approved SCC from this online resource while awaiting outcome of the CCS referral: https://www.dhcs.ca.gov/services/ccs/scc/Pages/SCCType.aspx.

   c. For all age groups, kidney, corneal, and autologous islet cell transplants, are not required to be performed at either a COE. These procedures may instead be performed at a CMS-approved OPTN member facility.

6. If the Member is deemed a suitable candidate by the appropriate facility, the facility will place the Member on the transplant waiting list.

7. Once a Member has been determined to be an appropriate surgical candidate for the organ transplant, the facility will submit a request for authorization of transplant surgery.[8]

   a. IEHP uses nationally recognized clinical criteria and/or IEHP UM Subcommittee-Approved Authorization Guidelines, when making decisions related to major organ transplants. Please see Policy 25E1, "Utilization Management - Delegation and Monitoring" for a description of decision process. Please see the DHCS Medi-Cal Provider Manual for detailed requirements of specific organ transplant procedures.

   b. Decisions for these referrals are made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Providers (see Attachment, "UM Timeliness Standards – Medi-Cal" in Section 14).

B. Under circumstances in which the transplant program cannot perform the MOT surgery and an organ is available, IEHP may arrange for the surgery to be performed at an out-of-network hospital. IEHP is responsible for ensuring the transplant program at this out-of-network hospital meets DHCS' COE requirements.[9]

C. The IPA will refer to IEHP any potential transplant candidates for care management services

[7] DHCS APL 21-015
[8] Ibid.
[9] Ibid.

by faxing the Transplant Team Referral Form to (909) 477-8542 (See Attachment, "Transplant Team Referral Form" in Section 12).

D. Please see Policy MC_11A, "Pharmacy Benefits and Services," for information on prescription drug coverage for major organ transplants.

E. IEHP, in collaboration with the IPA, coordinates all aspects of the referral, including providing to the COE all medical information (diagnostic tests, specialty physician notes, etc.) relevant to the particular major organ transplant; and assuring that the Member makes all appointments.

F. IEHP, in collaboration with the IPA, ensure coordination of care between all providers, organ donor entities, and transplant programs, for both the donor and the recipient, to ensure the MOT is completed as expeditiously as possible.[10]

G. To maintain an adequate network for this program, IEHP obtains from DHCS a list of Medi-Cal Approved Transplant COEs, which operate in a hospital setting, are certified and licensed through the Centers for Medicare and Medicaid Services (CMS) and meet Medi-Cal state and federal regulations.[11]

H. IEHP is responsible for the oversight and monitoring of its MOT network. If IEHP becomes aware that a contracted transplant program is no longer active, has lost its Medi-Cal approved COE status, is no longer enrolled to participate in the Medi-Cal program, or is no longer on DHCS' COE or SCC list, IEHP will notify impacted Members no later than 30 days prior to the planned inactivation date. IEHP will coordinate the redirection of care and services.[12]

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[10] DHCS APL 21-015
[11] Ibid.
[12] Ibid.

12. COORDINATION OF CARE

G. Organ Transplant

Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
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12. COORDINATION OF CARE

H. Community-Based Adult Services

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members.

POLICY:

A. Community-Based Adult Services (CBAS) are covered benefits under IEHP.[1] IEHP is responsible for authorization and payment of CBAS services.

B. The CBAS program provides services to older persons and adults with chronic medical, cognitive, or mental health conditions and/or disabilities who are at risk of needing institutional care. The intent of CBAS is to restore or maintain optimal capacity for self-care, delay or prevent inappropriate undesirable institutionalization, and engage the Member and/or caregiver, Primary Care Provider (PCP), and the community in working toward maintaining Member's independence.

PURPOSE:

A. To identify and coordinate care for Members requiring services at contracted CBAS centers.

B. To ensure Member access to CBAS equivalent services in all areas where a CBAS center is not available.

PROCEDURES:

CBAS Services

A. CBAS centers offer a package of health, therapeutic and social services in a community-based day care program.

1. Core services include:[2]
    a. Professional nursing services;
    b. Social services;
    c. Personal care services;
    d. Therapeutic activities; and
    e. Meal services (one (1) meal offered per day).
2. Additional services, if specified in the Member's Individualized Plan of Care (IPC), include:[3]
    a. Physical therapy;

[1] Department of Health Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 19, Provision 2, Covered Services
[2] DHCS Medi-Cal Provider Manual, "Community-Based Adult Services (CBAS)"
[3] ~~DHCS Medi-Cal Provider Manual, "Community-Based Adult Services (CBAS)"~~Ibid.

b. Occupational therapy;

c. Speech therapy;

d. Behavioral health services;

e. Registered dietician services;

f. Social services; and

g. Transportation to/from CBAS center to Member's place of residence.

~~g.~~3. CBAS centers must also make available to Members emergency remote services (ERS), when all ERS criteria, as described in this policy, are met.[4]

B. Each CBAS center shall have a multidisciplinary team of health professionals who conduct a comprehensive assessment of each potential participant to determine and plan services needed to meet the individual's specific health and social needs.

C. Members have the right to select a CBAS center of their choosing, as per appropriate California Department of Health Care Services (DHCS) guidelines.[5]

D. IEHP will reimburse CBAS centers the daily rate for eligible Members who attend four (4) hours or more in any given day at the CBAS center.[6]

E. The Member's assigned PCP remains responsible for providing primary care and all necessary referrals for specialty services, diagnostic testing and other services.[7]

Identification of CBAS Cases

A. Members who would benefit from CBAS services may be identified by multiple sources and will include those with the following conditions:

1. Serious and/or complex medical conditions requiring rehabilitative services;
2. Physical or psychiatric disability that limits the performance of activities of daily living but do not require twenty-four (24) hour institutional care;
3. Present level of functioning would either be maintained or improved if receiving preventative services; and/or
4. High potential for further impairment and probable need for institutional care if additional services are not received.

B. IEHP's determination of eligibility for CBAS may be requested by Members, caregivers, PCPs, Specialists, nursing facilities, hospitals, Community-Based Organizations (CBO), CBAS Providers, or other Providers assisting with Member's care.

[4] DHCS All Plan Letter (APL) 22-020 Supersedes APL 20-007, "Community-Based Adult Services Emergency Remote Services"
[5] DHCS Medi-Cal Provider Manual, "Community-Based Adult Services (CBAS)"
[6] California's Bridge to Reform Demonstration 1115 (11-W-00193/9), Community-Based Adult Services (CBAS) Amendment, Standards of Participation~~, 06/05/14~~
[7] DHCS Medi-Cal Provider Manual, "Community-Based Adult Services (CBAS)"

C. Members who would benefit from CBAS may be identified through any of the following:

1. Routine or other office visits to the PCP or Specialist, including by other office, clinic, hospital, or nursing facility staff;
2. Evaluation of requested specialty referrals, including requests for rehabilitation services or Members with significant illness requiring multiple specialty referrals;
3. The discharge planning process, concurrent case review or referral;
4. Grievances or other Member contacts;
5. Calls to IEHP or CBAS centers by Member or on behalf of a Member that needs assistance; and
6. For Seniors and Persons with Disabilities (SPD) Members, through Health Risk Assessments (HRA).

Eligibility Criteria for CBAS

A. IEHP will make CBAS eligibility determination in accordance with regulatory requirements.[8]

B. In order to be considered for the CBAS Program, the Member must be 18 years of age or older and meets one (1) or more of these conditions:[9]

1. Has been determined by DHCS to meet the Nursing Facility-A (NF-A) Level of Care or above;
2. Has Organic/Acquired or Traumatic Brain Injury and/or Chronic Mental Health condition;
3. Alzheimer's Disease or other Dementia Stage 5, 6, or 7;
4. Mild Cognitive Impairment, including moderate Alzheimer's (Stage 4);
5. Significant chronic medical illness; and/or
6. Developmental disability; and
7. In addition to which, the Member shall need assistance or supervision with either:
    a. Two (2) of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or
    b. One (1) need from the above and one (1) of the following: money management, accessing community and health resources, meal preparation, or transportation.

CBAS Referral Process

A. If the IPA or PCP receives a request for CBAS services or identifies a potential CBAS candidate, the IPA or PCP shall forward the request immediately to the IEHP Utilization

[8] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 19, Provision 4, Assessment and Reassessment for CBAS
[9] DHCS Medi-Cal Provider Manual, "Community-Based Adult Services (CBAS)"

Management (UM) Department through the secure IEHP Provider web portal or by fax at (909) 890-5751 for processing.

B. The PCP is responsible for the submission of a current history and physical and proof of negative Tuberculosis (TB) test results to the CBAS center.[10]

C. The IPA's Care Manager assists the PCP with completion of the referral, telephonic monitoring of potentially eligible Members, monitoring the status of Members, facilitating any needed transfer of medical records, and coordinating any necessary specialty services for Members.

D. IEHP is available for assistance with eligibility questions, coordination of care and other questions regarding CBAS center services.

CBAS Authorization Process

A. CBAS authorization requests must include the signature of the Member's PCP or Care Manager.

B. Authorization is valid for six (6) months. IEHP requires CBAS centers to submit a Member's IPC with the authorization extension request at least every six (6) months. [11]

C. Routine New Cases

1. Upon receipt of the request for CBAS, the IEHP UM Department will forward the authorization request to IEHP CBAS Team for completion of the DHCS-Approved CBAS Eligibility Determination Tool (CEDT) face-to-face assessment.

    a. For Members in a hospital or nursing facility, whose discharge plan includes CBAS, or Members facing imminent and serious threat to their health, a face-to-face assessment may not need to be performed.[12]

    b. For all other Members, the face-to-face evaluation will be done within thirty (30) calendar days of the authorization request.

2. CBAS centers will perform a multidisciplinary team assessment and then submit prior authorization requests with the Member's IPC and recommended Level of Service (LOS) to IEHP UM Department.

3. Following review of Member's IPC and recommended LOS with CBAS RN, IEHP UM Medical Director determines CBAS LOS approval within five (5) business days.

D. Expedited New Cases

1. Upon receipt of the expedited authorization request from UM, the IEHP CBAS RN will conduct the face-to-face assessment by using CEDT.

2. Approval or denial of CBAS eligibility will be sent to the CBAS center within seventy-

[10] DHCS Medi-Cal Provider Manual, "Community-Based Adult Services (CBAS)"
[11] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 19, Provision 4, Assessment and Reassessment for CBAS
[12] Ibid.

two (72) hours of the receipt of the request.[13,14]

3. CBAS centers will perform multi-disciplinary team assessment and then submit prior authorization requests with Member's IPC and recommended LOS to IEHP UM Department.
4. Following review of Member's IPC and recommended LOS with CBAS RN the IEHP UM Medical Director determines CBAS LOS approval in accordance with regulatory requirements.[15]

E. Existing Cases

1. Six (6) months from the original CBAS approval date, CBAS centers will re-assess Member and send prior authorization request including IPC with LOS recommendation to IEHP UM Department.[16]

F. Members that are referred for CBAS by their PCP or IPA, as part of a care plan, must be care managed by the IPA to assure coordination of care until the Member is approved for CBAS services.

G. Once the Member has been approved for CBAS services, the IEHP CBAS staff will coordinate services with the respective IPA, as needed.

H. Members not accepted into the CBAS Program will continue to receive medical care through their PCP and their IPA and should be referred for other appropriate services as needed.

CBAS Unbundled Services

A. If there are no CBAS centers or if there is a lack in capacity at CBAS centers in the Member's local area and the Member qualifies for CBAS services, IEHP will preauthorize "equivalent" unbundled services.[17] These unbundled CBAS services are the health plan's financial responsibility. These services include:[18]

1. Professional Nursing Services;
2. Nutrition;
3. Physical Therapy;
4. Occupational Therapy;
5. Speech and Language Pathology Services; and

[13] California Health and Safety Code (Health & Saf. Code), § 1367.01
[14] California's Bridge to Reform Demonstration 1115 (11-W-00193/9), Community-Based Adult Services (CBAS) Amendment, Standards of Participation~~, 06/05/14~~
[15] CA Health & Saf. Code, § 1367.01
[16] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 19, Provision 4, Assessment and Reassessment for CBAS
[17] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 19, Provision 1, Provider Network
[18] ~~Department of Health Services (~~DHCS~~)~~-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 19, Provision 2, Covered Services

6. Non-Emergency Medical Transportation only between the Member's home and the CBAS unbundled service Provider.

B. In addition to the requirements for unbundled CBAS, IEHP will coordinate care for unbundled CBAS services, based on the assessed needs of the Member that is eligible for CBAS, that are not covered services. These include:[19]

1. Personal Care Services;
2. Social Services;
3. Physical and Occupational Maintenance Therapy;
4. Meals; and
5. Mental Health Services.

CBAS Emergency Remote Services

A. Effective October 1, 2022, IEHP will cover emergency remove services (ERS) as a mode of service delivery if the Member meets all ERS criteria and all required ERS policy and procedures are followed. The CBAS center, in consultation with IEHP, may determine the need for ERS in these unique circumstances:[20]

1. Public emergencies, such as state or local disasters, regardless of whether formally declared. These may include, but are not limited to earthquakes, floods, fires, power outages, epidemic/infectious disease outbreaks such as COVID-19, tuberculosis, Norovirus, etc.
2. Personal emergencies, such as serious illness or injury or crises, or care transitions, such as to or from a nursing facility, hospital, and home.

B. The CBAS center must support the rapid response to the Member's needs, when they are restricted or prevented from receiving services at the center.[21]

1. The CBAS center must ensure that emergencies resulting in ERS are assessed initially by the CBAS center's RN and social worker, with care plans modified as needed by the full CBAS multidisciplinary team.[22]
2. When need for ERS is appropriately assessed and determined, the CBAS center must complete and fax the CBAS ERS Initiation Form (CEIF) form to IEHP's Utilization Management department at (909) 890-5751 for review and confirmation.[23]
3. To support rapid response to the Member's needs, the CBAS center must not wait for

[19] ~~Department of Health Services (~~DHCS~~)~~-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 19, Provision 2, Covered Services
[20] DHCS APL 22-020
[21] Ibid.
[22] Ibid.
[23] https://aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/Forms_and_Instructions/Emergency_Remote_Services/

notification from IEHP.

4. On a monthly basis, IEHP will provide CBAS centers a list of Members identified to be receiving ERS based on review of CEIF submissions.

C. The provision of ERS supports and services is temporary and time-limited, and specifically either:[24]

1. Short-Term – The Member may receive ERS for an emergency occurrence for up to three (3) consecutive months; and

2. Beyond Three (3) Consecutive Months – ERS for an emergency occurrence may not exceed three (3) consecutive months, either within or crossing over an authorized period, without assessment and review of possible continued need for remote/telehealth delivery of services and supports as part of the reauthorization of the Member's care plan.

In both of the above, IEHP and the CBAS center must coordinate to ensure that the duration of ERS is appropriate. IEHP will reach out to Members receiving ERS telephonically to verify that service and supports needs are being met during the duration of ERS.

D. CBAS centers and IEHP may consider the following to determine initial need for and/or duration of ERS. Should there be any concerns regarding the appropriateness of ERS, IEHP and the CBAS center must collaboratively agree on the method of providing ERS.[25]

1. Medical necessity – services and supports are necessary to protect life, address or prevent significant illness or disability, or to alleviate severe pain;

2. Hospitalization – whether the Member has been hospitalized related to an injury or illness and is returning home but not yet to the CBAS center;

3. Restrictions set form by the Members primary or personal health care provider due to recent illness or injury;

4. Member's overall health condition;

5. Extent to which other services or supports meet the Member's needs during the emergency; and

6. Personal crises such as sudden loss of caregiver or housing that threaten the Member's health, safety and welfare.

E. Within 30 days of discharge from CBAS, IEHP must review and retain a copy of the Member's discharge plan from the CBAS center. IEHP must review the discharge plan to determine if the Member needs further coordination of care or services. When there are unmet needs due to the discharge from CBAS, IEHP must ensure the Member's needs are met through other covered non-CBAS services and that these needs are updated appropriately in the Member's care plan.[26]

[24] DHCS APL 22-020
[25] Ibid.
[26] Ibid.

F. IEHP will provide oversight of its contracted CBAS Providers' compliance with ERS requirements per DHCS APL 22-020 and All Center Letters issued by the California Department of Aging through data and reporting, and monitoring of CBAS-related grievances.

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12. COORDINATION OF CARE

I. Complex Case Management

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP, in collaboration with the Member's Primary Care Provider (PCP), provides complex case management (CCM) services, which include:[1]

1. Basic case management services;
2. Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
3. Intense coordination of resources to ensure Member regains optional health or improved functionality; and
4. With the Member and their PCP's input, development of care plans specific to individual needs, and updating these care plans at least annually.

B. PCPs provide basic care management services[2] and are responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining continuity of care.[3]

PURPOSE:

A. To ensure the coordination of care and services for the highest risk Members with complex conditions and help them access needed resources.[4]

DEFINITION:

A. Complex Case Management – The systematic coordination and assessment of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.[5]

PROCEDURES:

A. IEHP does not delegate CCM responsibilities to its IPAs. IPAs may instead, refer to IEHP's Behavioral Health and Care Management (BH & CM) Department Members that may benefit

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 1, Comprehensive Case Management Including Coordination of Care Services
[2] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 1, Comprehensive Case Management Including Coordination of Care Services
[3] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 1, Definitions
[4] National Committee for Quality Assurance (NCQA), 2021 Health Plan Standards and Guidelines, PHM 5
[5] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 1, Definitions

from CCM services, including information that supports the complex need. The CM Referral Form can be found on the IEHP website at www.iehp.org or on the secure IEHP Provider portal (See Attachment, "IEHP Care Management Referral Form" in Section 25).

Member Identification

A. Identification of Members for CCM include data and referral sources, which identify health risk factors, complex social needs, and behavioral health concerns.

B. Members needing CCM services typically have (a) health condition(s) status that is severe in nature and without intensive assistance the Member would likely decline or use acute services more frequently. Members needing CCM level of assistance often require numerous or extensive resource coordination to improve their health or circumstances. The following CCM Program Trigger List was developed as a general guide for identifying Members that may benefit from CCM and should be used in combination with considering the following questions:[6]

1. ~~Is the Member's current situation severe?~~ Does the Member have two (2) or more chronic medical conditions not being managed, along with social determinant concerns such as food insecurity, financial concerns, housing, or other factors that may affect the Member's decisions/health status?
2. ~~Is the level of assistance needed intense and likely to require numerous/extensive resource coordination?~~ Is the Member's condition expected to progress in complexity and/or result in hospitalizations/ER visit (s) without resources and specialists?
3. ~~2.~~ Does the Member have one or more complex behavioral health conditions not being managed effectively and would need multiple resources/specialists?

Triggers for CCM include but are not limited to:

Diagnosis Triggers

1. Advanced Liver Disease
2. Metastatic Cancer
3. Pediatric Cancer
4. Decompensating Neurological Conditions
5. ~~New Cerebral Neurological Conditions~~
6. ~~6.~~5. New Cerebral Vascular Accident
7. ~~Complex Pain Management Control Issues~~
8. ~~8.~~6. Trauma (current)

[6] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 1, Comprehensive Case Management Including Coordination of Care Services

~~9. Multiple Chronic Illnesses – uncontrolled~~

7. Chronic uncontrolled (physical condition and/or behavioral health symptoms) that impact Member's activities of daily living (ADL)

8. Chronic homelessness impairing the ability to function in the community

AND/OR

Utilization Triggers

1. Six (6) or more ER visits in the past 6 ~~twelve (12)~~ months
2. Four (4) or more inpatient stays for physical or behavioral health (self-reported) in the past 12 months ~~in the past twelve (12) months~~
3. ~~On six (6) or more medications to treat chronic conditions and/or polypharmacy for the same medical/behavioral health conditions Two (2) or more readmissions to acute setting~~
4. ~~On multiple medications for multiple chronic conditions~~
5. ~~5.~~3. Projected cost of care within a twelve (12)-month period anticipated to be > $100,000 (including high cost medications and/or DME)

AND/OR

Psychosocial/Frailty Triggers

1. Weight loss of more than eight (8) pounds per month or 48 pounds in six months
2. Severe vision impairment needing total dependence to complete ADLs
3. Prescence of Decubitus Ulcer (2 or more at Stage III; 1 at Stage IV)

~~1. Malnutrition and/or Catabolic illness~~

~~2. Dementia~~

~~3. Severe Vision Impairment~~

~~4. Decubitus Ulcer~~

~~5. Major Problems of Urine Retention or Control~~

~~6. Loss of Weight~~

~~7. Absence of Fecal Control~~

~~8. Social Support Needs (Lack of Housing, inadequate Housing, inadequate material resources)~~

~~9. Difficulty Walking~~

~~10. Fall (fall on stairs or steps, fall from wheelchair)~~

~~11. Suspected or reported abuse of Member~~

12. COORDINATION OF CARE

I. Complex Case Management

Member Referrals

A. IEHP will review referrals to its CCM program. On a monthly basis, IEHP will provide IPAs through the Secure File Transfer Protocol (SFTP), a CCM report that identifies the following:

1. Members assigned to the IPA that are in active CCM with IEHP as of report run date;
2. Members assigned to the IPA that were closed from CCM with IEHP in the previous month with the reason for CCM closure included; and
3. Members assigned to the IPA that were referred to IEHP for CCM but where not opened to CCM as of report run date, because the Member did not meet criteria.

B. IPAs are responsible for reviewing cases and evaluating Members who did not meet CCM criteria. IPAs must outreach to these Members and assess for care coordination and case management needs.

Monitoring and Oversight

~~A.~~ While IEHP does not delegate CCM to its IPAs, IEHP will review cases that potentially qualify and assess for appropriate referral. Please see Policy 25C1, "Care Management–Delegation and Monitoring" for more information on monitoring and oversight activities.

A.

INLAND EMPIRE HEALTH PLAN		
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12. COORDINATION OF CARE

I. Complex Case Management

Chief Title: Chief Medical Officer	**Revision Date:**	January 1, ~~2022~~2023

12. COORDINATION OF CARE

J. Dental Services

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members.

POLICY:

A. Primary Care Providers (PCPs) are required to perform dental screenings and oral health assessments for all Members as part of the initial health assessment (IHA) and periodic health examinations.[1] Please see Policies 10A, "Initial Health Assessment," 10B, "Adult Preventive Services" and 10C1, "Pediatric Preventive Services – Well Child Visits" for more information.

B. Dental services may be provided to Medi-Cal Members on a fee-for-service (FFS) basis through Denti-Cal.[2] IEHP provides covered medical services related to dental services that are not provided by dentists or dental anesthetists, including prescription drugs, laboratory services, physical examinations required for admission for a dental procedure.[3,4]

PROCEDURES:

A. IEHP provides medically necessary federally required dental services including fluoride varnish for adults that may be performed by a medical professional.[5] Please see Policy 10C1, "Pediatric Preventive Services – Well Child Visits" for information on dental services for pediatric Members.

B. IEHP is responsible for the facility component and services related to dental procedures that require intravenous sedation and general anesthesia that are provided by a physician anesthesiologist or certified registered nurse anesthetist for Medi-Cal Members who need dental services performed by a licensed dentist that are reasonable and necessary for the prevention, diagnosis, and treatment of dental disease, injury or defect. A dental procedure may be provided under general anesthesia in a setting deemed appropriate.[6]

C. Adult Denti-Cal services are available to Members age 21 and above. Dental services are covered under Medi-Cal FFS for Members under age 21 and for pregnant women per Denti-Cal specific allowable procedure codes.[7]

D. PCPs refer Medi-Cal Members needing dental services to Denti-Cal Practitioners by giving

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27) Exhibit A, Attachment 11, Provision 15, Dental
[2] DHCS All Plan Letter (APL) 15-012 (Revised) Supersedes Policy Letter (PL) 13-002, "Dental Services – Intravenous Sedation and General Anesthesia Coverage"
[3] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27) Exhibit A, Attachment 11, Provision 15, Dental
[4] DHCS APL 15-012
[5] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27) Exhibit A, Attachment 11, Provision 15, Dental
[6] Ibid.
[7] Ibid.

the Member the Denti-Cal Practitioner referral phone number, (800) 322-6384.[8] PCPs can also refer Medi-Cal Members needing dental services to IEHP Member Services at (800) 440-IEHP (4347) for assistance in accessing the Denti-Cal Practitioner referral line.

E. PCPs and IPAs continue to provide all necessary health care services to Members even if referred to a dental Practitioner for services.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2022

[8] California Department of Health Care Services, Medi-Cal Dental Member Contact Information, ~~**Error! Hyperlink reference not valid.**~~https://www.dental.dhcs.ca.gov/Contact_Us/Medi-Cal_Dental_Member_Contact_Information/

12. COORDINATION OF CARE

J. Dental Services

12. COORDINATION OF CARE

K. Behavioral Health

1. Behavioral Health Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. Primary Care Providers (PCPs) and other health care Providers are required to provide behavioral health and/or substance use services within their scope of practice.[1,2,3,4]

~~A.~~B. IEHP and its County Mental Health Plan (MHP) partners administer standardized, statewide Adult and Youth Screening and Transition of Care Tools for Members under 21 (youth) and for Members age 21 and over (adults). These tools guide referrals of adult and youth Members to the appropriate Medi-Cal mental health delivery system and ensure that Members requiring transition between delivery systems receive timely coordinated care.[5]

~~B.~~A. ~~IEHP is responsible for non-specialty mental health services (NSMHS) to Members, who are:[6]~~

~~1. 21 years of age and older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined in the current Diagnostic and Statistical Manual of Mental Disorders;~~

~~2.~~1. ~~Under the age of 21, to the extent they are eligible for services through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, regardless of the level of distress or impairment, or the presence of a diagnosis;~~

~~3.~~1. ~~Under the age of 21, with specified risks or with persistent mental health symptoms in the absence of a mental health disorder, are subject to psychotherapy;[7] and~~

~~4.~~1. ~~Of any age with potential mental health disorders not yet diagnosed.~~

C. In both Riverside and San Bernardino Counties, Medi-Cal Specialty Mental Health (SMHS) are organized through the County ~~Mental Health Plans (~~MHP~~)~~s namely,~~-~~ Riverside University Health Services – Behavioral Health (RUHS-BH) and San Bernardino County ~~Behavioral~~

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 8, Services for All Members
[2] DHCS All Plan Letter (APL) 22-006 Supersedes APL 17-018, "Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services"
[3] Memorandum of Understanding (MOU) between the IEHP and Riverside University Health System-Behavioral Health (RUHS-BH), Mental Health Services, 01/01/18
[4] MOU between IEHP and San Bernardino County Department of Behavioral Health (SBDBH), Behavioral Health Services, 12/14/20
[5] DHCS APL 22-028, "Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services"
~~[6] DHCS APL 22-005, "No Wrong Door for Mental Health Services Policy"~~
~~[7] DHCS APL 22-006~~

Department of Behavioral Health (SBDBH) ~~Departments~~.[8] ~~County MHPs are responsible for providing medically necessary behavioral health services to children and SMHS to adults (ages 21 and older) who meet access criteria for SMHS.[9,10,11]~~

DEFINITIONS:

A. Specialty Mental Health Services (SMHS) – Refer to services provided by the County MHPs for Medi-Cal Members who meet access criteria for SMHS.[12]

B. Non-Specialty Mental Health Services (NSMHS) - Refer to services provided by IEHP BH Providers to IEHP Members as described in this policy.

PROCEDURES:

Covered Benefits

A. IEHP is responsible for non-specialty mental health services (NSMHS) to Members, who are:[13]

   1. 21 years of age and older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined in the current Diagnostic and Statistical Manual of Mental Disorders;

   2. Under the age of 21, to the extent they are eligible for services through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, regardless of the level of distress or impairment, or the presence of a diagnosis;

   3. Under the age of 21, with specified risks or with persistent mental health symptoms in the absence of a mental health disorder, are subject to psychotherapy;[14] and

   4. Of any age with potential mental health disorders not yet diagnosed.

B. County MHPs are responsible for providing medically necessary behavioral health services to children and SMHS to adults (ages 21 and older) who meet access criteria for SMHS.[15,16,17]

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[8] DHCS Behavioral Health Information Notice (BHIN) 21-073, "Criteria for Beneficiary Access to SMHS, Medical Necessity and Other Coverage Requirements"
[9] ~~MOU between IEHP and RUHS-BH, 01/01/18~~
[10] ~~MOU between IEHP and SBDBH, 02/12/18, 2/14/20~~
[11] ~~DHCS Behavioral Health Information Notice (BHIN) 21-073, "Criteria for Beneficiary Access to SMHS, Medical Necessity and Other Coverage Requirements"~~
[12] DHCS Behavioral Health Information Notice (BHIN) 21-073, "Criteria for Beneficiary Access to SMHS, Medical Necessity and Other Coverage Requirements"
[13] DHCS APL 22-005, "No Wrong Door for Mental Health Services Policy"
[14] DHCS APL 22-006
[15] MOU between IEHP and RUHS-BH, 01/01/18
[16] MOU between IEHP and SBDBH, 02/12/18, 2/14/20
[17] DHCS Behavioral Health Information Notice (BHIN) 21-073, "Criteria for Beneficiary Access to SMHS, Medical Necessity and Other Coverage Requirements"

~~A.~~C. IEHP is not responsible for payment of the following behavioral health services, which are carved out to the County MHPs:

1. Acute inpatient psychiatric hospital services;
2. Substance use services; and/or
3. SMHS outpatient behavioral health services such as:
   a. Mental health assessments, plan development, therapy, rehabilitation, and collateral services;
   b. Medication support;
   c. Day treatment services and day rehabilitation;
   d. Crisis and adult residential treatment;
   e. Crisis intervention and crisis stabilization;
   f. Targeted case management;
   g. Intensive care coordination;
   h. Intensive home-based services; and
   i. Therapeutic foster care and behavioral services.

~~B.~~D. IEHP does not impose Quantitative or Non-Quantitative Treatment Limitations to its timelines and processes more stringently on plan-covered mental health and substance use disorder services than are imposed on medical/surgical services.[18]

~~C.~~E. IEHP provides access to the following NSMHS, as medically necessary, when provided by network PCPs, Specialists, or other licensed mental health professionals within their scope of practice.[19] Please see Policy 14D, "Pre-Service Referral Authorization Process" for more information.

1. Individual mental health evaluation and treatment (no authorization is required for initial evaluation for therapy and psychiatry);
2. Group and family psychotherapy;
3. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition;
4. Outpatient services for the purpose of monitoring medication therapy;
5. Outpatient laboratory tests, supplies, supplements and prescription medications, including physician-administered drugs (excluding anti-psychotic medications which are covered by Medi-Cal Fee-For-Service) administered by a health care professional in a

[18] Title 42 Code of Federal Regulations (CFR) §§ 438.900, 438.910(d)
[19] DHCS APL 22-005

clinic, physician's office or outpatient setting through the medical benefit, to assess and treat mental health conditions;

6. Psychiatric and therapy follow up or ongoing visits;
7. Medications for Addiction Treatment (MAT, also known as medication-assisted treatment) provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings;
8. Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT);[20]
9. Up to twenty (20) individual and/or group counseling sessions for pregnant and postpartum individuals with specified risk factors for perinatal depression when sessions are delivered during the prenatal period and/or during the twelve (12) months following childbirth;[21] and
10. Autism assessments and Behavioral Health Treatment including Applied Behavioral Analysis (ABA), Occupational Therapy (OT), Physical Therapy (PT), and Speech and Language Therapy (ST) (See Policies 12D, "Early and Periodic Screening, Diagnosis and Treatment" and 12K3, "Behavioral Health Treatment").[22]

~~D.~~F. IEHP does not deny or disallow reimbursement for clinically appropriate and covered NSMHS even when:[23]

1. Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or SMHS access criteria are met;
2. Services are not included in an individual treatment plan;
3. The Member has a co-occurring mental health condition and substance use disorder (SUD); or
4. NSMHS and SMHS are provided concurrently if those services are coordinated and not duplicated.

~~E.~~G. Clinically appropriate and covered Drug Medi-Cal (DMC) services delivered by DMC providers and Drug Medi-Cal Organized Delivery System (DMC-ODS) are covered by counties participating in DMC-ODS, whether or not the Member has a co-occurring mental health condition.[24]

Identification/Diagnosis

[20] DHCS APL 21-014 Supersedes APL 18-014, "Alcohol and Drug Screening, Assessment, Brief interventions and Referral to Treatment"
[21] DHCS APL 22-006
[22] DHCS APL 19-014 Supersedes APL 18-006, "Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21"
[23] DHCS APL 22-005
[24] ~~DHCS APL 22-005~~Ibid.

A. PCPs and other health care Providers are responsible for identifying Members with behavioral health conditions that require referral to behavioral health specialists for treatment and triage according to the level of urgency.[25] Identification of these Members can occur during routine visits.

B. PCPs and BH Providers are responsible for diagnosing and treating Members' behavioral health conditions within their scope of practice.[26,27,28]

~~1. PCPs and other Providers may call the following numbers for advice or consultation regarding the Member's behavioral health issues, including diagnostic or treatment consultation, or the appropriateness of a referral.~~ PCPs and other Providers may advise Members who are exhibiting severe symptoms which impair their Activities of Daily Living ~~(~~**and** who are ~~**NOT**~~**not** currently in treatment with a BH Provider~~)~~ to contact their respective County BH Call Centers:

C.

~~2.~~1. **Riverside County Residents:**
CARES Line
(800) 499-3008

~~3.~~2. **San Bernardino County Residents:**
San Bernardino County Access Unit
(888) 743-1478

~~4.~~3. **IEHP Behavioral Health & Care Management Department:**
Monday-Friday 8:00am-5:00pm
Provider Line: (909) 890-2054
Member Line: (800) 440-4347
Fax Number: (909) 890-5763

Screening for Mental Health Services

A. IEHP administers standardized DHCS-issued Adult and Youth Screening Tools when a Member or a person on behalf a Member under age 21, who is not currently receiving mental health services. These screening tools:[29]

1. Identify indicators of Member needs in order to make a determination for referral to either an in-network Provider for a clinical assessment and medically necessary NSMHS or the County MHP for a clinical assessment and medically necessary SMHS;

[25] DHCS APL 22-006
[26] Ibid.
[27] MOU between IEHP and RUHS-BH, 03/12/18
[28] MOU between IEHP and SBDBH, 12/14/20
[29] DHCS APL 22-028

2. Are not required or intended for us with Members who are currently receiving mental health services;
3. Are not required to be used when Members contact mental health Providers directly to seek mental health services;
4. May be administered by clinicians or non-clinicians in a variety of ways, including in person, by telephone, or video conference;
5. Must be asked in full using the specific wording provided in the tool and in the specific order the questions appear in the tools, to the extent that the Member is able to respond;
6. Do not replace the following:
   a. IEHP's policies and procedures that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals;
   b. IEHP's protocols that address clinically appropriate, timely, and equitable access to care;
   c. IEHP's clinical assessments, level of care determinations and service recommendations; and
   d. IEHP's requirements to provide EPSDT services.

B. The Adult Screening Tool, which is used for Members age 21 and older, includes screening questions that are intended to elicit information about the following:

1. Safety: Information about whether the Member needs immediate attention and the reason(s) a Member is seeking services;
2. Clinical Experiences: Information about whether the Member is currently receiving treatment, if they have sought treatment in the past, and their current or past use of prescription mental health medications;
3. Life Circumstances: Information about challenges the Member may be experiencing, issues related to school, work, relationships, housing, or other circumstances;
4. Risk: Information about suicidality, self-harm, emergency treatment, and hospitalizations.

This also includes questions related to substance use disorder (SUD). If a Member responds affirmatively to these SUD questions, they are offered a referral to the County MHP for SUD assessment. The Member may decline this referral without impact to their mental health delivery system referral.[30] Please see Policy 12K2, "Substance Use Treatment Services" for more information.

[30] DHCS APL 22-028

C. The Youth Screening Tool, which is used for Members under the age of 21, includes screening questions that are intended to elicit information about the following: [31]

1. Safety: Information about whether the Member needs immediate attention and the reason(s) a Member is seeking services;
2. System Involvement: Information about whether the Member is currently receiving treatment, and if they have been involved in foster care, child welfare services, or the juvenile justice system;
3. Life Circumstances: Information about challenges the member may be experiencing related to family support, school, work, relationships, housing, or other life circumstances; and
4. Risk: Information about suicidality, self-harm, harm to others, and hospitalizations.

This also includes questions related to SMHS access and referral to other services.

D. These screening tools, their contents, including the specific wording and order of fields must remain intact and unchanged.[32]

E. IEHP uses the scoring methodology provided in these screening tools are used to determine an overall score for each screen Member and whether they must be referred to an in-network Provider or the County MHP for clinical assessment and medically necessary services. [33]

F. IEHP coordinates Member referrals with County MHPs by sharing the completed screening tool and following up to ensure a timely clinical assessment has been made available to the Member. Members must be engaged in the process and appropriate consents obtained in accordance with accepted standards of clinical practice.[34]

G. IEHP allows its contracted mental health Providers who are contacted by Members seeking mental health services to begin the clinical assessment process and provide services during the assessment period without using the screening tools.[35]

Treatment

A. Certain behavioral health conditions beyond the PCP's scope of practice require treatment by a BH Provider. In these cases, the PCP can directly refer the Member to a BH Provider for an initial assessment without prior authorization.[36,37] ~~Once the need for SMHS is determined, the BH Provider and IEHP will collaborate in transitioning the Member to County MHP.~~

[31] Ibid.
[32] Ibid.
[33] Ibid.
[34] DHCS APL 22-028
[35] Ibid.
[36] DHCS APL 22-006
[37] 28 CCR § 1300.74.72(f)

B. Members referred to the County MHPs for behavioral health services remain enrolled in IEHP. IEHP, its IPAs and Providers remain responsible for all necessary physical health care.[38,39]

C. IEHP and County MHPs provide medically necessary behavioral health interventions:[40,41]

1. For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity," when it is reasonable and necessary to protect life, to preventive significant illness or significant disability, or to alleviate severe pain.

2. For individuals under 21 years of age, services, including NSMHS, are "medically necessary" or a "medical necessity," when the services are necessary to correct or ameliorate defects and physical and mental illnesses or conditions that are discovered by screening services, regardless of whether services are covered by Medi-Cal.[42,43,44] Behavioral health services need not be curative or completely restorative to ameliorate a behavioral health condition, which is consistent with federal guidance from the Centers for Medicare and Medicaid Services (CMS).[45] Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary and covered under the EPSDT mandate.[46]

3. Treatment may include the provision of appropriate psychotropic medications as well as acute crisis intervention.[47,48]

4. IEHP provides medically necessary Behavioral Health Treatment (BHT) services for all Members that meet criteria, even without a diagnosis of autism spectrum disorder (ASD).[49,50] See Policy 12K3, "Behavioral Health – Behavioral Health Treatment" for more information.

Referral Process

A. IEHP processes all requests for BH or Substance Use Disorder (SUD) services in compliance with State and Federal regulatory requirements, including requirements for parity in mental

[38] MOU between IEHP and RUHS-BH, 03/12/18
[39] MOU between IEHP and SBDBH, 12/14/20
[40] California Welfare & Institutions (Welf. & Inst.) Code § 14059.5
[41] CA Welf. & Inst. Code § 14184.402
[42] DHCS APL 19-010
[43] DHCS – IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 5, Services for Members under Twenty-One (21) Years of Age
[44] Title 42 United States Code (USC) § 1396(d)
[45] DHCS APL 22-006
[46] DHCS APL 22-006~~Ibid.~~
[47] MOU between IEHP and RUHS-BH, 03/12/18
[48] MOU between IEHP and SBDBH, 12/14/20
[49] DHCS APL 19-010 Supersedes APL 18-007 and APL 07-008, "Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21"
[50] DHCS APL 19-014

health and substance use disorder benefits.[51,52] See Policy 12K2, "Behavioral Health – Substance Use Treatment Services" for more information about substance use services and referrals.

B. IEHP does not require prior authorization for initial mental health assessment. IEHP covers the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service within the applicable timely and access requirements.[53] IEHP's Behavioral Health and Care Management (BH & CM) Department can assist in the referral process for all Members. Members may be directed to IEHP BH & CM Department through several sources, which include, but are not limited to:

1. Member or their representative;
2. PCPs and other Providers;
3. County agencies;
4. IPAs; and
5. IEHP Departments.

C. IEHP will process requests for BH services. Determinations are made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Providers.[54] See Policy 14D, "Pre-Service Referral Authorization Process" for more information.

1. Expedited/Urgent Referrals
    a. In the event a Member needs urgent access to NSMHS and is NOT experiencing a behavioral health crisis or psychiatric emergency, the Provider can call, fax, or send an electronic referral through the secure IEHP Provider portal.
    b. If a Member presents with a life-threatening psychiatric emergency or behavioral health crisis (e.g., Member is a danger to self or others, is making threats of violence) the Provider must follow their own emergency protocol (e.g., call 911). Please see Policies 14C, "Emergency Services" and 9A, "Access Standards" for more information.
    c. Assistance with locating a hospital emergency department is available after hours through the Nurse Advice Line at (888) 244-4347.
2. Standard or Non-Emergent Referrals

[51] 42 CFR § 438.910(d)
[52] CA Health and Safety Code (Health & Saf. Code) § 1367.01
[53] DHCS APL 22-006
[54] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures

a. PCPs and Specialists, with the assistance from the Member's IPA care management staff as needed, are responsible for referring Members to the IEHP BH & CM Department.

b. When a Member contacts the County Mental Health system and the County determines that the Member is not eligible for SMHS Services, the County will refer the Member to IEHP.

c. For routine referrals that do not require urgent access to services, the County will submit a BH web form referral to IEHP.

D. IEHP will provide continuity of care in accordance with applicable regulatory requirements.[55] Please see Policy 12A2, "Care Management Requirements – Continuity of Care" for more information.

~~Specialty Mental Health Services~~ Transition of Care Tool for Medi-Cal Mental Health Services

A. If a Member is currently in treatment with an IEHP BH Provider or County MHP and is identified as possibly needing ~~Tier III SMHS~~to be transitioned to the other delivery system, the ~~BH~~ treating Provider will ~~inform IEHP~~complete the Transition of Care tool through the secure IEHP Provider portal. ~~The BH Provider continues to provide behavioral health services until a determination is made and/or the Member is transitioned to the appropriate County MHP.~~

B. The Transition of Care Tool is intended to ensure that Members, including adults age 21 and older and youth under age 21, who are receiving mental health services from one delivery system receive timely and coordinated care when either: (1) their existing services are being transitioned to the other delivery system; or (2) Services are being added to their existing mental health treatment from the other delivery system.[56] This tool:

1. Documents the Member's information and provide information from the entity making the referral to the receiving delivery system to begin the Member's care transition;

2. Leverages existing clinical information to document a Member's mental health needs and facilitate a referral for a transition of care to, or addition of services from the Plan or County MHP, as needed;

3. Documents the IEHP's contact information and care team, Member demographics and contact information, Member behavioral health diagnosis, cultural and linguistic requests, presenting behaviors/symptoms, environmental factors, behavioral health history, medical history, and medications, and requested services;

[55] DHCS APL ~~18-008~~22-032 (Revised) Supersedes APL ~~15-019~~18-008, "Continuity of Care for Medi-Cal Members who newly enroll~~Who Transition into~~ in Medi-Cal Managed Care from Medi-Cal Fee-for-Service, and for Medi-Cal Members who transition into a new Medi-Cal Managed Care Health Plan on or after January 1, 2023"
[56] DHCS APL 22-028

4. Designed to be used for both adults and youth alike and may be administered in a variety of ways, including in person, by telephone or by video conference;

5. Do not replace the following:

   a. IEHP's policies and procedures that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals;

   b. IEHP's protocols that address clinically appropriate, timely, and equitable access to care;

   c. IEHP's clinical assessments, level of care determinations and service recommendations; and

   d. IEHP's requirements to provide EPSDT services.

C. The Transition of Care tool, its contents, including the specific wording and order of fields must remain intact and unchanged.[57]

D. The determination to transition services to and/or add services from the County MHP delivery system must be made by a clinician via a patient-centered shared decision-making process in alignment with Plan protocols. Members must be engaged in the process and appropriate consents must be obtained in accordance with accepted standards of clinical practice.[58]

E. A Member with established therapeutic relationship with an IEHP BH Provider may continue receiving NSMHS from the IEHP BH Provider (billed to IEHP), even if the Member simultaneously receives SMHS from a County MHP Provider (billed to the County MHP), as long as the services are coordinated between the delivery systems and are non-duplicative.[59]

Eating Disorders

A. IEHP and the County MHPs share a joint responsibility to provide medically necessary services to Medi-Cal Members with eating disorders. IEHP is responsible for the physical health components of eating disorder treatment and NSMHS, and County MHPs are responsible for the SMHS components of eating disorder treatment:[60]

   1. County MHPs provide, or arrange and pay for, medically necessary psychiatric inpatient hospitalization and outpatient SMHS.

   2. IEHP provides inpatient hospitalization for Members with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and who do not meet criteria for psychiatric hospitalization. IEHP also provides or arranges for NSMHS for Members requiring these services

[57] Ibid.
[58] Ibid.
[59] DHCS APL 22-005
[60] DHCS APL-22-003, "Medi-Cal Managed Care Health Plan Responsibility to Provide Services to Members with Eating Disorders"

3. IEHP covers and pays for emergency room professional services, including professional physical, mental, and substance use treatment services, including screening See Policy 14C, "Emergency Services" for more information.

B. IEHP coordinates all medically necessary care for Members, including locating, arranging, and following up to ensure services were rendered for partial hospitalization and residential eating disorder programs, when such treatment is medically necessary for a Member.[61][62]

C. IEHP maintains a Memoranda of Understanding (MOU) with both County MHPs that outline the following:[63,64,65]

1. Mutually agreed upon division of financial responsibilities;
2. Provider reimbursement requirements;
3. Care coordination and concurrent review activities; and
4. Description of timely and complete exchange of information between parties.

D. IEHP does not delay care management and care coordination, as well as coverage of medically necessary services pending the resolution of a dispute.[66]

~~Care Management~~IEHP Responsibilities

A. For Members concurrently receiving NSMHS and SMHS, IEHP coordinates their care with County MHP to ensure Member choice.[67]

B. ~~IEHP coordinates with County MHPs to facilitate care transitions and guide referrals for Members receiving NSMHS to transition to a SMHS Provider and vice versa.[68]~~ IEHP refers the Member to the County MHP and coordinates their care services with County MHPs to facilitate care transitions or addition of services, including ensuring that the referral process has been completed, the Member has been connected with a Provider in the new system, the new Provider accepts the care of the Member, and medically necessary services have been made available to the Member. All appropriate consents must be obtained in accordance with accepted standards of clinical practice.[69]

~~B.~~C. PCPs and BH Providers are responsible for maintaining communication with treating Providers, assigned IPAs and/or IEHP BH & CM Department to coordinate the Member's care.

~~D.~~[61] ~~DHCS APL 22-003~~ ~~Ibid.~~
[62] Ibid.
[63] Ibid.
[64] MOU between IEHP and RUHS-BH, 01/01/18
[65] MOU between IEHP and SBDBH, 12/14/20
[66] DHCS APL 22-003
[67] DHCS APL 22-005
[68] ~~Ibid.~~
[69] DHCS APL 22-028

~~C.~~D. IEHP BH & CM Department is available for consultation regarding complex cases or to assist with coordinating care with BH Providers, including County BH Providers.

Medications

A. IEHP is responsible for payment of most psychotropic medications when prescribed by an IEHP Provider. Most of the anti-psychotic (neuroleptics) medications and the medications that mitigate the side effects of anti-psychotic medications are excluded as a benefit administered by IEHP and are not paid for by IEHP but are instead covered by Medi-Cal Fee-For-Service (FFS).

B. IEHP Providers are responsible for writing prescriptions for medications that are medically necessary and providing any additional information required by IEHP or Medi-Cal FFS to obtain a particular medication (e.g., Prescription Drug Prior Authorization (RxPA) information).

C. Out-of-network physicians prescribing medications for Members must provide any additional information requested by IEHP or Medi-Cal FFS.

Releasing Member Information

A. IEHP Providers must release medical information and behavioral health or substance use treatment records upon request by the IEHP BH & CM Department for coordination of care, when IEHP is the payer of services. Refer to Policy 7B, "Information Disclosure and Confidentiality of Medical Records."

B. Providers may use their own Release of Information (ROI) form or use IEHP's Authorization for Use or Disclosure of Patient Health Information Form (see Attachments, "Authorization for Use or Disclosure of Protected Health Information – English" and "Authorization for Use or Disclosure of Protected Health Information – Spanish" in Section 10).

Reporting and BH Web Forms

A. PCPs, IPAs and BH Providers utilize the secure IEHP Provider portal and BH web forms to submit requests, transition care and review reports.

B. PCPs must inform IEHP of Members identified to have significant or complex behavioral health conditions using the BH web forms on the secure IEHP Provider portal.

~~C. PCPs and BH Providers refer Members to IEHP for behavioral health services using the BH web form on the secure IEHP Provider portal.~~

~~D.~~C. BH Providers must submit the "Coordination of Care Treatment Plan" through the secure IEHP Provider portal as follows:

1. Prior to the expiration date of the authorization, request continued services, when medically necessary;

2. When a Member requires transition to SMHS;

~~2.~~3. When a Member needs additional SMHS;

~~3.~~4. When a Member no longer needs medically necessary services, the Member discharges from treatment, and/or when treatment is terminated for any reason; and

~~4.~~5. Provide results of a second opinion three (3) business days after the second opinion was performed. Please see Policy 14B, "Second Opinions" for more information.

E. All IPAs, PCPs and BH Providers can access BH web forms on the secure IEHP Provider portal. Providers can receive training on how to use the secure IEHP Provider portal or how to complete the BH web forms by calling the IEHP Provider ~~Relations Team~~Call Center at (909) 890-2054 or emailing providerservices@iehp.org.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

12. COORDINATION OF CARE

K. Behavioral Health
2. Substance Use Treatment Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP, its IPAs, and Providers identify Members requiring substance use disorder treatment services and arrange for their referral to the County Behavioral Health Department for substance use treatment, or other community resources.[1]

PROCEDURES:

Identification/Diagnosis

A. Provision or arrangement of medically necessary care for acute medical conditions related to substance use, such as delirium tremens or gastrointestinal hemorrhage, is the responsibility of the Primary Care Provider (PCP) or the Specialist.

B. PCPs must complete the initial health assessment (IHA) for all new Members within one hundred twenty (120) calendar days of their enrollment.[2] An IHA includes a review of pertinent health related behaviors including smoking, alcohol and drug use, exercise, etc.[3] as well as the Staying Healthy Assessment (SHA) through which the PCP can identify alcohol misuse.[4,5,6] Subsequent contact with the Member provides PCPs the opportunity to evaluate the Member's health and screen regarding substance use problems. Please see Policies 10A, "Initial Health Assessment," 10B, "Adult Preventive Services," 10C1, "Pediatric Preventive Services – well Child Visit," and 15F, "Individual Health Education Behavioral Assessment/Staying Healthy Assessment," for more information on alcohol and drug screening, assessment, brief interventions and referral to treatment.[7]

C. Members with substance use problems may also be identified through:

1. Utilization Management (UM) activities;
2. Care Management (CM) activities;

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 7, Alcohol and Substance Use Treatment Services
[2] DHCS Policy Letter (PL) 08-003, "Initial Comprehensive Health Assessment"
[3] Ibid.
[4] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 3, Initial Health Assessment
[5] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 8, Services for All Members
[6] DHCS PL 08-003
[7] DHCS All Plan Letter (APL) 21-014 Supersedes APL 18-014, "Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)"

3. Provider referrals; and
4. Pharmacy utilization management activities.

Treatment

A. IEHP does not impose Quantitative or Non-Quantitative Treatment Limitations to its timelines and processes more stringently on plan-covered mental health and substance use disorder services than are imposed on medical/surgical services.[8]

B. PCPs are responsible for all necessary physical and mental health care for Members with substance use problems within their scope of practice.[9,10] Depending on the specific substance use problem and the health status of the Member, services may include:

1. Alcohol and Drug Screening, Assessment, Brief Intervention, and Referral to Treatment (SABIRT);
2. Limited or comprehensive physical exam with appropriate diagnostic testing to rule out associated medical conditions (e.g., hepatitis, endocarditis);
3. Mental status exam with appropriate treatment or referral for any actual or potential associated psychiatric conditions; or
4. Referral to specialty Providers for evaluation as necessary.

C. The PCP must discuss recommendations for treatment with the Member, develop a treatment plan, and/or as appropriate, refer them to the appropriate County Substance Abuse Service Agency.

Referral Process

A. PCPs, IPAs, and BH Providers are responsible for referring Members with substance use problems to an appropriate treatment program covered through the county substance abuse treatment program.[11]

B. PCPs, Specialists, and BH Providers, who identify a potential need for services are responsible for referring IEHP Medi-Cal Members to the appropriate County Substance Abuse Service Agency:

1. **Riverside County Residents:**
   Substance Use Community Access, Referral, Evaluation, and Support
   (800) 499-3008

[8] Title 42 Code of Federal Regulations (CFR) §§ 438.900 *et seq*.
[9] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 8, Services for All Members
[10] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 20, Provision 4, Outpatient Mental Health Care Services
[11] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 7, Alcohol and Substance Abuse Treatment Services

2. **San Bernardino County Residents:**
   Substance Abuse Referral Service
   (800) 968-2636

C. IEHP Behavioral Health & Care Management (BH & CM) Department can assist with facilitating referrals to the appropriate County Substance Abuse Service Agency's referral unit, as necessary. [12,13]

1. IEHP BH & CM Department contact information:

   Monday-Friday 8:00am-5:00pm
   Provider Line: (909) 890-2054
   Member Line: (800) 440-4347
   Fax Number: (909) 890-5763

2. Expedited/Urgent Referrals

   a. If a Member presents with a life-threatening psychiatric emergency or behavioral health crisis (e.g., Member is a danger to self or others, is making threats of violence) the Provider must follow their own emergency protocol (e.g., call 911). Please see Policies 14C, "Emergency Services" and 9A, "Access Standards" for more information.

   b. Assistance with locating a hospital emergency department is available after hours through the Nurse Advice Line at (888) 244-4347.

   c. Any Medi-Cal Member presenting to a Provider or facility with an acute substance use problem requiring an immediate detoxification evaluation may be referred to the appropriate County Substance Abuse Referral Unit.

   d. Any Member presenting with acute withdrawal symptoms requiring medical detoxification should be referred to a contracted hospital emergency department.

3. Standard Non-Emergent Referrals

   a. PCPs and/or Specialists are responsible for referring Members with non-emergent substance abuse conditions to the appropriate local County Substance Abuse Agency's Referral Unit.

   b. IEHP refers Members to community resources as necessary.

   c. Members who respond affirmatively to the alcohol pre-screen question on the SHA or are identified by their PCP to potentially misuse alcohol are referred to the County

[12] Memorandum of Understanding (MOU) between IEHP and Riverside University Health System-Behavioral Health (RUHS-BH), Mental Health Services, 03/12/18
[13] MOU between IEHP and San Bernardino County Department of Behavioral Health (SBDBH), Mental Health Services, 12/14/20

Behavioral Health Department.[14]

D. Members referred for substance use treatment to a County Substance Abuse Service Agency remain enrolled in IEHP and the assigned PCP, Provider, and IPA remain responsible for all necessary physical health care.

E. IEHP BH & CM Department coordinates with the County Substance Abuse Service Agency to refer Members to available treatment outside of the Plan's service area, when substance use treatment services are not available within its service area.

Covered Benefits

A. Inpatient services are available for medical detoxification, when medically necessary (i.e. when Member has a qualifying medical condition for hospital admission), for the treatment of substance abuse at a participating hospital.[15] Authorization for this service is coordinated through IEHP's Utilization Management Department.

B. Outpatient services including evaluation, crisis intervention, and treatment, when medically necessary, are provided through the corresponding County Substance Abuse Agency based on the Member's county of residence. The County Substance Abuse Agency is responsible for approving substance use services, not IEHP.[16]

C. Multidisciplinary Medication Assisted Treatment is available for the treatment of Opioid Use Disorder (OUD) through contracted network Providers. Members may self-refer to services by calling IEHP Member Services. Providers may refer Members through IEHP Provider Services.

D. Members may self-refer to Community Based Organizations (CBOs) for care and assistance on a self-pay basis.

Case Management

A. IEHP BH & CM Department can assist the PCP with the referral process, follow up with Members referred for substance use treatment, and facilitate the Member's transition back into the primary care setting. IEHP BH & CM Department continues to case manage Members before, during, and after referral and/or treatment.

B. PCPs, IPAs and BH Providers are responsible for maintaining communication with substance use providers to coordinate the Member's care.

Releasing Member Information

A. PCPs and BH Providers must maintain procedures to ensure appropriate records processing

[14] DHCS APL 21-014
[15] Title 9 California Code of Regulations § 1820.205(a)
[16] DHCS APL 17-018 Supersedes 13-021, "Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services"

to prevent breach of confidentiality.[17,18] Refer to Policy 7B, "Information Disclosure and Confidentiality of Medical Records," for information pertaining to the release of medical records.

B. IEHP Providers must release medical information and behavioral health or substance use treatment records upon request by the IEHP BH & CM Department for coordination of care when IEHP is the payer of services. Refer to Policy 7B, "Information Disclosure and Confidentiality of Medical Records."

C. Whenever a Release of Information is completed, all Providers shall adhere to confidentiality requirements.[19]

Reporting and Web Forms

A. PCPs, IPAs and BH Providers utilize the secure IEHP Provider portal and BH web forms to submit requests and review reports.

B. IPAs, PCPs and BH Providers can refer Members to IEHP or the appropriate County Substance Abuse Agency using IEHP's BH web forms on the secure IEHP Provider portal when the Member is in agreement with the referral.

C. IPAs, PCPs and BH Providers can receive training on how to use the secure IEHP Provider portal or how to complete the BH web forms by calling the IEHP Provider Relations Team at (909) 890-2054 or emailing providerservices@iehp.org.

[17] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 1, Member Rights and Responsibilities
[18] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 13, Medical Records
[19] 42 CFR § 431.306

INLAND EMPIRE HEALTH PLAN		
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12. COORDINATION OF CARE

K. Behavioral Health

3. Behavioral Health Treatment

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Members.

POLICY:

A. IEHP provides and covers all medically necessary Behavioral Health Treatment (BHT) services for eligible[1] Members under 21 years of age.[2] ~~.~~ This applies to any health condition, including children diagnosed with autism spectrum disorder (ASD) and children for whom a licensed physician, surgeon, or psychologist determines that BHT services are medically necessary.[3]

B. IEHP is responsible for ensuring that all of a Member's needs for medically necessary BHT services are met across environments, including on-site at school or during virtual school sessions.

~~BHT is a benefit for those under age 21 under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.[4,5] Please see Policy 12D, "Early and Periodic Screening, Diagnostic and Treatment" for more information regarding EPSDT benefit. The Member must have a current authorization before BHT services can be provided. A Member must:[6]~~

- ~~Be under 21 years of age;~~
- ~~Have a recommendation from a licensed physician, surgeon or psychologist that evidence-based BHT services are medically necessary;~~
- ~~Be medically stable; and~~
- ~~Be without need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).~~

~~A.~~

PURPOSE:

A. To ensure benefits and services are provided in a standardized manner to Members in accordance with State health care regulations.

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[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 23-005 Requirements for coverage of early and periodic screening, diagnostic, and treatment services for Medi-Cal members under the age of 21.

[3] Department of Health Care Services (DHCS) All Plan Letter (APL) ~~19-014~~23-010 Supersedes APL ~~18-006~~19-014, "Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21"

~~[4] DHCS APL 23-010~~

~~[5] DHCS APL 23-005~~

~~[6] DHCS APL 23-010~~

DEFINITIONS:

A. Behavioral Health Treatment (BHT) – These services include applied behavioral analysis and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. The goal is to promote, to the maximum extent practicable, the functioning of a beneficiary, including those with or without ASD.[7]

B. Applied Behavioral Analysis (ABA) – The process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior.[8]

PROCEDURES:

BHT Coverage

~~A. Primary Care Providers (PCPs) must provide initial and periodic health assessments in accordance with the Recommendations for Preventive Pediatric Health Care that is based on the consensus statement from the American Academy of Pediatrics (AAP) and Bright Futures.[9] Please see Policy 10C1, "Pediatric Preventive Services – Well Child Visits," for more information.~~

A. IEHP covers all necessary EPSDT services, including BHT services, regardless of whether California's Medicaid State Plan covers such services for adults, when the BHT services have an ameliorative, maintenance purpose.

~~B.~~ C. BHT is a benefit for those under age 21 under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.[10,11] ~~S~~Please see Policy 12D, "Early and Periodic Screening, Diagnostic and Treatment" for more information regarding EPSDT benefit. The Member must have a current authorization before BHT services can be provided. A Member must:[12]

1. Be under 21 years of age;
2. Have a recommendation from a licensed physician, surgeon or psychologist that evidence-based BHT services are medically necessary;
3. Be medically stable; and
4. Be without need for 24-hour medical/nursing monitoring or procedures provided in a

[7] DHCS APL ~~19-014~~23-010
[8] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 1, Definitions
[9] ~~Ibid.~~
[10] DHCS APL ~~19-014~~23-010
[11] DHCS APL ~~19-010~~23-005
[12] DHCS APL ~~19-014~~23-010

hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).

D. BHT is provided, observed, and directed under an approved BHT plan developed by ~~(a)~~ BHT Provider(s), which includes ABA and other evidence-based methodologies.[13]

E. BHT is provided by a qualified autism Provider who meets the requirements in California's Medicaid State Plan or a licensed Providers acting within the scope of their licensure.

F. IEHP provides medically necessary supplementary BHT services and addresses any gap in services caused when a Local Education Agency (LEA) discontinues the provision of BHT services.[14]

G. IEHP ensures members have access to and support medication adherence for the carved-out prescription.

H. IEHP complies with mental health parity requirements when providing BHT services, which requires that the Plan disclose utilization management criteria.

I. IEHP uses nationally recognized clinical criteria and/or IEHP UM Subcommittee Approved Authorization Guidelines, when making decisions related to medical care, including BHT services. IEHP ensures an appropriate independent review of Member's medical needs for BHT services in accordance with EPSDT requirements and medically accepted standards of care~~current clinical criteria and guidelines when determining what BHT services are Medically Necessary~~. ~~—~~See Policy 25E1, "Utilization Management Delegation and Monitoring" for more information.

~~C.~~ J. IEHP will offer Members continuity of care from an out-of-network provider of BHT services for up to twelve (12) months if required conditions are met.[15] ~~Please~~ See Policy 12A2, "Care Management Requirements – Continuity of Care" for more information.

BHT Treatment Plan ~~Provider Responsibilities~~

A. The BHT treatment plan must identify the medically necessary services to be provided in each community setting in which treatment is medically indicated, including on-site at school or during remote school sessions.

~~A.~~B. The approved BHT treatment plan must also meet the following criteria:[16]

1. Include a description of ~~patient~~ Member information, reason for referral, brief background information (e.g., demographics, living situation, home/school/work information), clinical interview, review of recent assessments/reports, assessment

[13] Ibid.
[14] Ibid.
[15] DHCS APL 18-008 Supersedes APL 15-019, "Continuity of Care for Medi-Cal Members who Transition into Medi-Cal Managed Care"
[16] DHCS APL ~~19-014~~23-010

procedures and results, and evidence based BHT services;

2. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors;
3. Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation;
4. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives;
5. Include the Member's current level of need (baseline, ~~behavior parent/guardian is~~ expected behaviors the Guardian will ~~to~~ demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan of generalization and report goal as met, not met, modified (include explanation);
6. Utilize evidence based BHT services with demonstrated clinical efficacy tailored to the Member;
7. Clearly identify the service type, number of hours of direct service(s), observation and direction, ~~parent/~~Gguardian training, support and participation needed to achieve the goals and objectives, the frequency at which the Member's progress is measured and reported, transition plan, crisis plan, and each individual Provider responsible for delivering the services;
8. Include care coordination involving the Guardian~~parents or caregiver(s)~~, school, state disability programs and other programs and institutions, as applicable;
9. Consider the Member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision;

~~9. The Plan will not reduce the number of Medically Necessary BHT hours that a Member is determined to need by the hours the Member spends at school or participating in other activities;~~

10. Deliver BHT services in a home or community-based setting, including clinics; and~~.~~ ~~BHT intervention services provided in schools, in the home, or other community settings, must be clinically indicated, Medically Necessary and delivered in the most appropriate setting for the direct benefit of the Member. BHT service hours delivered across settings, including during school, must be proportionate to the Member's medical need for BHT services in each setting Any portion of medically necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and community; and~~

11. Include an exit plan/criteria; however, only a determination that services are no longer Mmedically Nnecessary under the EPSDT standard can be used to reduce or eliminate services.

C. The BHT provider must review, revise, and/or modify no less than once every six months the BHT treatment plan. If services are no longer Medically Necessary under the EPSDT medical necessity must be modified or discontinued.[17]

D. IEHP permits the Member's Guardian(s) to be involved in the development, revision, and modification of the BHT treatment plan to promote Guardian participation in treatment.[18]

~~11.~~

~~BHT intervention services provided in schools, in the home, or other community settings, must be clinically indicated, medically necessary and delivered in the most appropriate setting for the direct benefit of the Member. BHT service hours delivered across settings, including during school, must be proportionate to the Member's medical need for BHT services in each setting.~~

~~The Plan will not reduce the number of medically necessary BHT hours that a Member is determined to need by the hours the Member spends at school or participating in other activities. BHT Providers will only deliver services as authorized by IEHP. BHT Providers must make an adequate number of professionals and paraprofessionals available to deliver BHT services to Members within access standards. See Policy 9A, "Access Standards" for more information.~~

BHT Provider Responsibilities

~~B.~~A. BHT Providers must adhere to the following access standard~~s~~ for BHT:

1. Appointment for initial assessment must be offered within ten (10) business days of authorization being approved.[19] See Policy 9A, "Access Standards" for more information.

~~2. Upon receipt of BHT authorized hours, BHT Provider will assign a treatment team to the Member within fifteen (15) business days to initiate services.~~

~~3. Members should never be placed on a waiting list for treatment services. If at any time the BHT Provider cannot meet the above stated timelines, the BHT Provider must contact the Provider Relations Team at (909) 890-2054.~~

~~4. If the BHT Provider experiences difficulties with contacting the Member to setup the initial appointment, IEHP encourages the BHT Provider to maintain a record of all attempts to contact the Member and written correspondence sent to the Member.~~

~~5. BHT Providers will have ongoing communication with IEHP regarding access and capacity to accept referrals.~~

[17] DHCS APL 23-010
[18] Ibid.
[19] Title 28, California Code of Regulations (CCR) § 1300.67.2.2

~~C. BHT Providers must submit each assessment and progress report to IEHP at least seven to ten (7-10) business days prior to the authorization term date.~~

~~D. BHT Providers must cooperate with the efforts of IEHP to evaluate BHT services, including but not limited to, collection of outcome metrics, quality improvement and peer review.~~

~~E. BHT Provider will utilize only BHT Providers and BHT Professionals who are credentialed by IEHP.~~

~~F. Each BHT Provider and BHT Professional who delivers BHT services to a Member will be employed and supervised by a BHT Provider. The supervisory relationship will be described in a formal, written supervision document.~~

~~G.~~B. ~~BHT Provider must promptly notify IEHP, in writing, if at any time BHT Provider determines that BHT Provider no longer satisfies the requirements of applicable laws and/or regulations.~~BHT Provider must promptly notify IEHP, in writing, if at any time BHT Provider determines that BHT Provider no longer satisfies the requirements of applicable laws and/or regulations.

BHT Services

~~A.~~ All BHT services provided by the BHT Provider under this policy require prior authorization. See ~~policy~~ Policy 12K1, "Behavioral Health – Behavioral Health Services" for more information.

~~B. BHT Provider staff must log their hours during each session. The parent or a caregiver over the age of 18 will need to sign off on the hours after each session. The BHT Provider may only submit claims for those hours signed by the parent or caregiver. IEHP may request records of hour logs from the BHT Provider at any time (see Attachment, "ABA Service Hour Log" in Section 12).~~

~~C. Functional Behavior Assessments (FBAs) are one hundred and twenty (120) day authorizations. The BHT Provider must provide IEHP and the Member's PCP an FBA report at least seven to ten (7-10) business days before the authorization end date. Data must be submitted through the secure IEHP Provider portal. In addition to BH web forms, a detailed report should be attached.~~

~~1. FBA is a billable service separate from direct services and supervision. FBA will need to be completed by a BHT Provider and BHT Professional may assist BHT Provider.~~

~~2. A maximum of ten~~Ten (10) ~~hours may be authorized to complete an FBA.~~

~~3. FBA identifies target behaviors, environmental factors influencing each behavior, antecedent conditions triggering the behaviors as well as the consequences maintaining them.~~

~~4. FBA should include the intervention plan that leads to socially significant improvement in Member's and family's lives and result in a decrease in target behaviors by addressing socially appropriate functional alternative replacement behaviors.~~

~~5. Member's skill sets (e.g., obtaining desired items, self-help skills, and following instructions) will be assessed and an individual training plan will be created for the Member and parents.~~

~~6. Goals should be measurable, developmentally appropriate, socially significant, and include mastery criteria. These goals should also include but not be limited to:~~

~~a. Comparing Member's performance to the performance of a normative sample;~~

~~b. Asking consumers to rate the social validity of Member's performance;~~

~~c. Asking experts to evaluate Member's performance;~~

~~d. Using a standardized test instrument; and~~

~~e. Testing the Member's newly learned level of performance in the natural environment.~~

~~7. Hours requested for ABA services include direct service hours, supervision, and parent training should be supported with clinical data outlined in FBA report (See Attachment, "BHT FBA Report Template" in Section 12found in the IEHP website).[20]~~

~~8. Social Skills training should be facilitated by licensed and certified practitioners. Social skills training should be provided using evidence and research based curriculum. Based upon the BHT Provider's chosen curriculum, certification and training may be applicable (See Attachment, "BHT Social Skills Template" in Section 12found in the IEHP website).[21]~~

~~D.~~A. ~~ABA services are to be provided in the home setting with the presence of a parent or caregiver.[22] [23]BHT Providers may provide services in the school setting as long as it is clinically proportionate to hours provided in the natural setting,[24] and not to exceed 50% of hours.[25] BHT Provider must complete the "School Request Form" when requesting prior authorization for hours in the school setting (See Attachment, "In School BHT Services Request Form" in Section 12).~~

B. BHT intervention services provided in schools, in the home, or other community setting must be clinically indicated, medically necessary and delivered in the most appropriate setting for the direct benefit of the Member. BHT service hours delivered across settings, including during school, must be proportionate to the Member's medical need for BHT services in each setting.

C. BHT Providers can submit an amendment for additional treatment hours. This may be needed when school is out of session or there is an increase in maladaptive behaviors, etc. The BHT Provider must include the clinical justification for the increase in hours. The plan will review

~~[20] https://www.iehp.org/en/providers/provider-resources?target=forms~~
~~[21] https://www.iehp.org/en/providers/provider-resources?target=forms~~
~~[22] DHCS APL 19-01423-010~~
~~[23] DHCS APL 23-010~~
~~[24] Ibid.~~
~~[25] Ibid.~~

and approve as medically necessary. Submit the request via the Coordination of Care Treatment Plan form found on the Provider Portal.

~~E.~~D. The Plan will not reduce the number of medically necessary BHT hours that a Member is determined to need by the hours the Member spends at school or participating in other activities.

~~F.~~ Authorizations for BHT will not extend past the Member's 21st birthday. For Members who are within sixty (60) days of their 21st birthday, the BHT Provider must initiate the transition process to an alternative funding source (e.g., Regional Center, County Services, or Department of Rehabilitation).

~~G. BHT Providers of BHT services must review, revise, and/or modify the behavioral treatment plan no less than once every six (6) months. the behavioral treatment plan[26].Every six (6) months, BHT Providers must submit to IEHP progress reports using the template provided in this manual (see Attachment, "6 Months and Exit Progress Report Template" in Section 12). BHT Providers will should submit a Termination/Exit Report for the following reasons:~~

~~1. When Member's parent/caregiver has requested a termination, or change in BHT Provider for BHT service;~~

~~2. When Member no longer has eligibility for Medi-Cal or IEHP benefits;~~

~~3. When Member has reached the age of 21 years of age and BHT services are no longer covered under the EPSDT benefit;~~

~~4. When BHT Provider is discharging Member from treatment due to attendance issues. The BHT Provider must clearly state and provide proof of documentation for contact attempts, record of cancelations, and/or company conflict resolution documentation addressing attendance and/or commitment.~~

~~5.~~E. ~~Only a determination that services are no longer medically necessary under the EPSDT standard can be used to reduce or eliminate services.[27]~~

F. The BHT Provider ~~must~~ may work collaboratively with other health care professionals involved in the care of a Member (e.g., PCP, Community Entities, Local Education Agencies, Regional Centers, Occupational Therapy, Speech Language Pathologist, Mental Health Provider).[28]

~~H. ;. Mmn~~

~~I.~~G. Exit criteria may be met when the Member has met the goals and objectives identified in the assessment plan or the treatment goals and objectives are no longer appropriate, and BHT is

~~[26] DHCS APL 23-010~~
~~[27] DHCS APL 19-014~~
[28] DHCS APL ~~19~~23-010

no longer medically necessary. Other exit criteria may include, but are not limited to the following:

1. Parents have a poor or conflicting relationship or alliance with the BHT Provider, the Member qualifies for a higher or lower level of care, and/or lack of improvement on goals, or failure to meet intervention goals. This may also be the case when other services are deemed more appropriate such as Speech Therapy or Occupational Therapy.
2. Members can also meet exit criteria when their goals are met.

~~**Parent Training and Involvement**~~

~~A. Parent Education Training workshops is a billable service to be completed by a parent or caregiver over the age of 18.~~

~~B. Parents are required to observe and participate during therapy sessions, receive parent training, and collect data. The level of parent participation may vary depending on Member's needs and stage in the program.~~

Coordination of Care

A. IEHP is required to establish data and information sharing agreements as necessary to coordinate the provision of services with other entities that may have overlapping responsibility for the provision of BHT services including but not limited to Regional Centers,[29] LEAs, and County Mental Health Plans.[30,31]

1. When another entity has overlapping responsibility to provide BHT services to the Member, IEHP is required to:

a. Assess the medical needs of the Member for BHT services across community settings according to the EPSDT standard;

b. Determine what BHT services (if any) are actively being provided by other entities;

c. Coordinate the provision of all services including Durable Medical Equipment (DME) and medication with the other entities to ensure that the Plan and the other entities are not providing duplicative services; and

d. Ensure that all of the Member's medical needs for BHT services are being met in a timely manner, regardless of payer, and based on the individual needs of the Member.

[29] Memorandum of Understanding (MOU) between IEHP and Inland Regional Center, Services for Developmentally Disabled Members, First Amendment, 01/01/21
[30] MOU between IEHP and San Bernardino County Department of Behavioral Health (SBDBH), Behavioral Health Services, 12/14/20
[31] MOU between IEHP and Riverside University Health System- Behavioral Health (RUHS-BH), Mental Health Services"

2. Medically Necessary BHT must not be considered duplicative when the Plan has overlapping responsibility with another entity for the provision of BHT services unless the service provided by the other entity is the same type of service (e.g., ABA), addresses the same deficits, and is directed to equivalent goals.

B. The Plan must not rely on LEA programs to be the primary Provider of medically necessary BHT services on-site at school or during remote school sessions and assume that BHT services included in a Member's Individualized Education Plan (IEP)/ Individualized Health and Support Plan (IHSP)/ Individualized Family Service Plan (IFSP) are actively being provided by the LEA.

C. If a Member's IEP team concludes that the Plan-approved BHT services are necessary to the Member's education, the IEP team must determine that the Plan-approved BHT services must be included in the Member's IEP. Services in a Member's IEP must not be reduced or discontinued without formal amendment of the IEP.

D. If the Plan-contracted Provider determines that BHT services included in a Member's IEP are no longer medically necessary, the Plan is required not to authorize the use of Medi-Cal funding to provide such services.

E. IEHP may attempt to obtain written agreement from the LEA to timely take over the provision of any Plan-approved BHT services included in the IEP upon a determination that the services are no longer medically necessary.

F. IEHP may coordinate with the LEA to contract directly with a school-based BHT services practitioner enrolled in Medi-Cal to provide any medically necessary BHT services included in a Member's IEP.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2017
Chief Title: Chief Medical Officer	**Revision Date:**	May ~~January~~ ~~4~~1, 2023

12. COORDINATION OF CARE

L. Vision Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. Vision services, including a comprehensive eye exam, lenses and frames for Medi-Cal Members are provided directly by IEHP per the Medi-Cal Vision benefit.

B. Optometry services for Medi-Cal Members include Diabetic Retinal Examination (DRE), Therapeutic Pharmaceutical Agents (TPA), diagnostic, ancillary and supplemental procedures used for the evaluation of the visual system. Vision Providers are required to obtain prior authorizations for all routine vision benefits.

PROCEDURES:

Initial Health Assessment – Vision Screening

A. The initial health assessment for children and adults must be performed by the Primary Care Provider (PCP) within sixty (60) days of enrollment for Medi-Cal Members under the age of 18 months and within one hundred twenty (120) days of enrollment for Members 18 months and older. A component of the initial health assessment requires vision screening of the eyes to determine the presence of eye disease or potential refractive errors. The PCP must advise the Member of findings and encourage the Member to seek vision services when appropriate. Refer to Policy 10A, "Initial Health Assessment" for more information.

Follow-up Vision Screening

A. The PCP must continue to observe Members for vision conditions and advise Members to seek vision services as applicable. Follow-up screenings for adults should take place during periodic routine physical exams as outlined in Policy 10B, "Adult Preventive Services." For children, periodic vision screenings should be performed in accordance with IEHP Well Child Visit requirements as outlined in Policy 10C1, "Pediatric Preventive Services – Well Child Visits."

Access to Vision Providers

A. PCPs are responsible for directing Members to an IEHP Vision Provider if non-medical vision conditions are noted during the visits or if the Member has Diabetes and is being referred for a Diabetic Retinal Exam (DRE).

B. Vision Providers can obtain prior authorization through IEHP's Vision Referral Request online at www.iehp.org or through the Provider Relations Team at (909) 890-2054.

Vision Providers for Medi-Cal Members

A. A Vision Provider list is included in the IEHP Provider Directory or can be obtained online at www.iehp.org. To receive assistance with referral, a Vision Provider may call IEHP

Provider Relations Team at (909) 890-2054. Members may also call IEHP Member Services at (800) 440-4347 to obtain assistance.

Vision Benefits for Medi-Cal Members

A. Members are limited to one bilateral comprehensive eye examination with refraction, including dilation when medically indicated, in a twenty-four (24) month period unless more frequent examinations are determined to be medically necessary.

1. All routine vision benefits require prior authorizations.
2. Providers are strongly encouraged to obtain self-service referrals through **IEHP's Vision Referral Request** online on the Provider Portal at www.iehp.org or through the Provider Relations Team at (909) 890-2054.
3. Before ordering services, Providers must verify eligibility through IEHP's Online Eligibility Verification System at www.iehp.org. When ordering medically necessary absorptive lenses, medical justification must be provided and prior authorization must be obtained. IEHP designated contract optical lab order forms are available online at www.iehp.org.
4. Eyeglass frames are covered for all Medi-Cal Members. Eyeglass frames provided to Members must be of good quality with the manufacturer's or American distributor's name or identification clearly stamped on the frame. Only frames that Providers supply to the general public may be given to Members. Discontinued or closeout frames are not covered and cannot be dispensed. The Provider must maintain an adequate supply of covered frames to allow sufficient choice by the Member (i.e., male/female and ten (10) choices for children).
5. In the event that services are not covered under the IEHP Plan or are denied by IEHP as not being medically necessary, for example non-covered cosmetic contact lenses or non-Medi-Cal benefit frames, **the Provider must not charge the Member unless the Provider has obtained a written waiver from the Member**. The waiver must be obtained in advance of rendering services and must specify those non-covered services or services IEHP has denied as not being medically necessary and must clearly state that the Member is responsible for payment of those services. Members must sign a Non-Covered Service/Materials Waiver Form ~~(See Attachments, "Non-Covered Services Waiver Form – English" and "Non-Covered Services Waiver Form – Spanish" in Section 12)~~ for expenses exceeding the covered material benefit. Non Covered Services Waiver Forms are accessible at: https://www.iehp.org/en/providers/provider-resources?target=forms#Vision.

B. Lenses are fabricated at the Prison Industry Authority (PIA) according to the DHCS contract for Medi-Cal Members. The lens specifications and frame are forwarded to the PIA for fabrication and returned to the Vision Provider for dispensing to the Member.[1]

[1] Department of health Care Services (DHCS) Medi-Cal Provider Manual. "Vision Care - Lenses"

1. Prior to ordering PIA services, Providers must verify eligibility and obtain the Member's county and aid code through IEHP's Online Eligibility Verification System at www.iehp.org. Providers must include the Member's 14-digit Medi-Cal ID number from the Benefit Identification Card (BIC) on the PIA order form.
   a. Riverside and San Bernardino County Providers must use California State Prison - Solano when ordering all lens prescriptions:
      1) California State Prison - Solano

         Prison Industry Authority

         Optical Laboratory

         2100 Peabody Road

         Vacaville, CA 95687

         Customer Service: ~~(800) 700-9861; (707) 454-3447~~ (800)541-5555

         Fax: (707) 454-3214
   b. Los Angeles County Providers must use Valley State Prison for Women when ordering all lens prescriptions:
      1) Valley State Prison ~~For~~for Women

         Prison Industry Authority

         Optical Laboratory

         23370 Road 22

         Chowchilla, CA 93610-4329

         Customer Service: (800) 377-8953; (559) 665-5531 ext 7427

         Fax: (559) 665-5147
   c. **Providers are to obtain order through the PIA Optical Web Site.**
      1) Set up your username and password at www.pia.ca.gov.
      2) For question call (866) 742-1542.
   d. PIA Optical Laboratory Order Books/Forms may be obtained by calling the toll-free phone numbers for the appropriate optical laboratory listed above.
   e. Only materials covered by Medi-Cal can be ordered from PIA.
2. If PIA is unable to complete the order, Providers must contact IEHP to obtain approval to use the following IEHP designated contract optical lab when ordering lens materials. IEHP Providers must use the IEHP Lab Order Form (See Attachment, "IEHP Lab Order Form" in Section 12) when ordering materials from the IEHP designated contract lab.

Express Lens Lab

17150 Newhope St., Suite 305

Fountain Valley, CA 92708-4251

(714) 545-1024 Phone

(714) 556-2026 Fax

Unique Optical

43990 Golf Center Pkwy Ste B2

Indio, CA 92203

(760) 391-9100~~(760) 835-2908~~ Phone

(760) 391-9101 Fax

C. Pediatric and Adult Members diagnosed with diabetes are entitled to an annual Diabetic Retinal Examination (DRE). Vision Providers are required to coordinate care with Member's PCP by notifying the PCP in writing of the results of the DRE.

1. Prior to rendering services, Providers are required to obtain a referral through IEHP's Vision Referral Request online at www.iehp.org or through the Provider Relations Team at (909) 890-2054.
2. For the purpose of benefit availability, annual shall mean once per calendar year but no less than nine (9) months since the last DRE.
3. DRE may be performed on the same day as a comprehensive examination if the Member is eligible for the periodic routine eye examination.
4. Vision Providers are required to coordinate care with the Member's PCP by notifying the Member's PCP in writing of the results of the DRE, utilizing the IEHP PCP Vision Report Form (See Attachment, "PCP Vision Report Form" in Section 12).

D. Members are limited to vision aids.[2]

1. A physician or optometrist must prescribe vision aids when medically necessary, after appropriate assessment.
2. Low Vision Aids require a Vision Exception Request (VER) to be submitted see Policy 12.L.1, "Vision Services - Vision Exception Request (VER)."

E. The IEHP Therapeutic Pharmaceutical Agents (TPA) Program allows IEHP credentialed and TPA certified Providers to perform specific services to Members without a referral from the Members' PCPs. In addition to performing TPA services an optometrist with TPG or TLG certification can diagnose and treat primary open angle glaucoma in patients over the age of 18 years old. IEHP follows Medi-Cal guidelines for referral requirements.

[2] Title 22 California Code of Regulations (CCR) §51317

L. Vision Services

1. Any IEHP Vision Provider may provide TPA services to Pediatric and Adult Members if the following minimum criteria are met:
   a. Provider is an ophthalmologist that participates in IEHPs vision program.
   b. Provider is credentialed by IEHP.
   c. Optometrists must be TPA, TPL, TPG or TLG certified as verified by the California Board of Optometry.
   d. Provider must be contracted by IEHP to provide those services.
   e. Symptoms and conditions covered under the Program are consistent with Section 3041 of the Business and Professions Code and Section 3051.76 of the Title 5 California Code of Regulations.[3,4]
   f. All Members with confirmed chronic conditions must be referred to their PCP unless Vision Provider has TPG and/or TLG certification to treat glaucoma.
2. Additional equipment that is required in order to provide TPA services includes:
   a. Binocular Indirect Ophthalmoscope.
   b. Condensing Lens.
   c. Automated Threshold Field Analyzer.
   d. Goldman Applanation Tonometer.
3. Prior to rendering services, Providers are required to obtain a referral in accordance to Medi-Cal guidelines through IEHP's Vision Referral Request online at www.iehp.org or through the Provider Relations Team at (909) 890-2054.
4. TPA services may not be performed on the same day as a comprehensive examination or Diabetic Retinal Examination (DRE).
5. TPA Providers are required to notify the Member's PCP that medical services have been provided within two (2) working days of rendering services. Providers must complete the PCP Vision Report form (See Attachment, "PCP Vision Report Form" in Section 12) which is available on the IEHP web portal at https://www.iehp.org/en/providers/provider-resources?target=forms.
6. A legible copy of the PCP Vision Report must be sent to the Member's assigned PCP.
   a. The Member's assigned PCP information can be found on the eligibility page of the secure Provider portal.
7. The PCP Vision Report form must be completed in its entirety and includes:
   a. Patient's presenting symptoms.

[3] California Code, Business and Professions Code §3041
[4] Title 5 California Code of Regulation (CCR) §3051.75

b. Diagnosis description.

c. ICD code(s).

d. Procedure(s) and/or treatment performed.

e. If applicable, the name and type (form) of medication prescribed.

f. Provider's signature.

g. Date of the next follow-up appointment, if indicated, in "Next Visit" otherwise specify N/A (not applicable).

8. Claims for TPA, TPG and TLG services can be submitted through **IEHP's Claims Entry** form on the IEHP Provider portal at www.iehp.org on a CMS 1500 Health Insurance Claim Form and must include all information necessary to process the claim for payment.

   a. Under the TPA Program, IEHP performs retrospective review on all non-authorized services. Claims are also reviewed for unbundling and inappropriate use of codes. Claims with unbundled services, or where two (2) or more lower level codes are billed on the same date of service without substantiated documentation, result in lower reimbursement.

   b. Members cannot be billed for any covered service, including services that have been denied because of improper billing.

9. Prescription Medications

   a. All prescription medications prescribed to IEHP Members must comply to IEHP's formulary. Providers wishing to prescribe non-formulary medication must first submit a Prescription Drug Prior Authorization (RxPA) Request form for approval.

   b. TPA Providers must use Prescription Drug RxPA Request forms for the following:

      1) Medication or dosage not included in the IEHP formulary.

      2) Code 1 medications used for treatment of conditions or criteria other than those specified by their restrictions.

      3) Branded medications when generic is available.

      4) Prescriptions for formulary medications that do not comply with Dose/Duration/or Quantity guidelines as outlined in the IEHP formulary at www.iehp.org under Pharmaceutical Services page.

      5) The RxPA form is available on the IEHP web portal at https://ww3.iehp.org/en/providers/pharmaceutical-services/pharmacy-rx-pa-universal-form/.

   c. A Member currently taking medication that has been deleted from IEHP's formulary may continue to receive the medication, if prescribed.

d. All completed Prescription Drug RxPA Requests will be reviewed within twenty-four (24) hours for approval or denial.

F. IEHP PCPs continue to provide all necessary health care services to Members even if the Member has been referred to a Vision Provider for services.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	July 1, 1998
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, ~~2022~~2023

12. COORDINATION OF CARE

L. Vision Services

1. Vision Exception Request

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. All non-routine benefits require prior authorization utilizing the Vision Exception Request (VER) form. Vision Provider must submit a completed VER form to obtain prior authorization.

B. All VERs must contain information that supports the medical necessity of a non-routine benefit.

C. VERs are required for replacement of eye appliances that are lost, stolen, or destroyed in circumstances beyond the Member's control and that exceed the Member's benefit.

D. All requests are reviewed and acted on based on the type of request submitted:

1. Routine (Non-urgent) Pre-Service: Decision within five (5) working days of receipt of all information reasonably necessary to render a decision.
2. Expedited Authorization (Pre-Service): Decision within seventy-two (72) hours of receipt of the request.
3. Post-Service / Retrospective Review: Decision within thirty (30) calendar days from receipt or request.

PROCEDURE:

A. Vision Providers can obtain prior authorization through IEHP's Vision Referral Request online at www.iehp.org or through the Provider Relations Team at (909) 890-2054.

B. Vision Exception Requests (VER) can be submitted for vision aids, including but not limited to:[1]

1. Second eye examination within twenty-four (24) months covered when signs or symptoms indicate a need and documentation substantiates the need for a second exam.
2. Medi-Cal Members are entitled to Single Vision Lenses in -lieu of Bifocals – Two (2) pairs of single vision glasses, one (1) for near vision and one (1) for distance vision are covered when one (1) of the following exists:
   a. Sufficient evidence that a Member cannot wear bifocal lenses.
   b. Member is currently using two (2) pairs of glasses.

[1] Title 22 California Code of Regulation (CCR) § 51317

c. New presbyopes must have failed with bifocals first.

3. Medi-Cal Members are entitled to replacement of lost, broken or damaged appliances may be covered when accompanied by a written statement signed by the Member that includes:
   a. The circumstances of the loss or destruction;
   b. The steps taken to recover the lost item; and
   c. Certification that the loss, breakage, or damage was beyond the Member's control.
4. Medi-Cal Members are entitled to Contact Lenses Only when medically necessary. Request for contact lenses must include sufficient clinical information and an explanation that justifies the request including, but not limited to:
   a. Valid diagnosis.
   b. Type of lens.
   c. Any other medical justification necessary to support the need for contact lenses.
5. Medi-Cal Members are entitled to Low Vision Aids covered when such aids can markedly enhance visual function with sufficient clinical information or explanation that justifies the request.
6. Other Covered Items- VER Required:
   a. Ptosis crutches, occluders, bandage contact lenses, prosthetic eyes and prosthetic scleral shells are covered when medically indicated. A brief justification must be provided when prescribing or dispensing the covered item.

C. When a VER is determined necessary, Vision Providers have two (2) working days from the determination to submit the VER and all supporting documentation.

D. IEHP reviews and responds to all VERs submitted as, Routine (Non-Urgent) Pre-Service within five (5) working days, Expedited (Pre-Service) within seventy-two (72) hours and Post-Service / Retrospective within thirty (30) calendar days from receipt or request. IEHP reviews the VER, verifies eligibility, benefit availability and previous utilization and either approves, modifies, or denies the request. All decisions are communicated to the Provider via a "Non-PHI fax" form.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2021

12. COORDINATION OF CARE

L. Vision Services
2. Vision Provider Referrals

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP Vision Providers are required to provide evaluation and management (E&M) services within their scope of practice to Members with known or suspected diseases and conditions of the eye and visual system.

B. Vision Providers caring for Medi-Cal Members that require further diagnosis and treatment beyond the scope of practice of the Vision Provider must refer the Member to the appropriate health care Provider, as follows:

1. Medi-Cal Members with a known or suspected pathology of the eye, or any of its appendages, may be referred directly by the Vision Provider to an Ophthalmologist by submitting a referral request to the Member's assigned IPA or IEHP, as applicable.

2. Medi-Cal Members with a known or suspected medical condition that may be systemic or neurological in nature shall be referred to the Member's Primary Care Provider (PCP) for appropriate coordination of care.

~~3.~~ Vision Providers may also call the IEHP Provider Relations Team at (909) 890-2054 for assistance regarding information on the Member's IPA or IEHP contact assignment for referral submission.

3.

PROCEDURES:

Identification/Diagnosis

A. Vision Providers are responsible for identifying Members with any pathological ocular health condition that requires treatment. Identification of these Members can occur during the routine physical examination of the eyes and visual system and through review of the past medical history or review of systems, or during any visit for acute or chronic conditions.

B. Vision Providers are responsible for diagnosing and treating Members' pathological ocular health conditions that are within their scope of practice.[1]

C. Members presenting with complex or mixed symptoms or conditions that make the diagnosis uncertain or that may indicate a systemic etiology must be referred to the Member's PCP for assessment, diagnosis, and/or treatment. If the Vision Provider determines that an

[1] Business and Professions Code (BPC) § 3041

ophthalmologist consultation and/or treatment is warranted, the Vision Provider can submit a referral directly to the Member's assigned IPA or IEHP, as applicable.

D. Vision Providers are responsible for treating Members with ocular conditions within their scope of practice. Treatment includes the provision of appropriate optical devices and the use of topical ophthalmic pharmaceutical agents, as indicated. Typical ocular health conditions within the scope of practice of Vision Providers, depending on their level of certification and legal authority include, but are not limited to:

1. Refractive and motility disorders of the human eyes
2. Ocular infections
3. Ocular inflammations and allergies
4. Ocular trauma and superficial foreign bodies
5. Primary open angle glaucoma
6. Nothing in this section shall be construed to grant privileges to the optometric Vision Provider beyond the scope set forth in the statutes and regulations of the Optometry Code.[2,3]

E. Scope and limitations to IEHP Medi-Cal Vision Benefit: IEHP Medi-Cal Members are entitled to a routine comprehensive eye examination every twenty-four (24) months and, if medically indicated. Eyeglass frames and lenses are covered for Members every twenty-four (24) months. When indicated, medical evaluation and management services of certain eye conditions are available to the Member through an IEHP Vision Provider. Treatment of any eye condition shall be limited to acute conditions. The long-term treatment of chronic medical conditions of the eyes shall be managed and coordinated by the Member's PCP.

Referral to PCP

A. Vision Providers shall complete a PCP Vision Report (See Attachment, "PCP Vision Report Form" in Section 12) to report examination findings and/or treatment provided during an active ocular condition that require further evaluation or follow up by Member's PCP.

1. To ensure Member's continuity of care, Vision Providers are required to notify the Member's PCP if medical services have been provided within two (2) days of rendering service.

Referral to Ophthalmologist

A. Vision Providers, with the assistance of the IPA Utilization Management (UM) staff, are responsible for referring Medi-Cal Members to the appropriate ophthalmologist specialty Provider for assessment, diagnosis and treatment as needed.

[2] BPC § 3041
[3] California Code of Regulations (CCR) § 1569

B. PCPs are also responsible for referring Members to the appropriate ophthalmologist specialty Provider for assessment, diagnosis and treatment as needed.

C. PCPs are responsible for direct coordination of the clinical care of the Member in concert with the ophthalmologist specialty Provider through phone calls, transfer of medical records, and other specialty referrals as indicated.

D. Vision Providers shall prepare a written request for referral on the standardized Ophthalmologist Referral Request Form at www.iehp.org (See Attachment, "Ophthalmologist Referral Form" in Section 12) and submit the completed referral to the Member's assigned the IPA within twenty-four (24) hours of the encounter with the Member. Direct Vision Providers can submit a Referral Request Form via the Secure Provider Portal in lieu of a written request. Vision Providers may indicate desired ophthalmological sub-specialty by selecting: General Ophthalmology, Retinal Specialist or Pediatric Ophthalmology.

E. IPA UM staff are responsible for faxing back a copy of the completed referral form including the specific ophthalmologist selected back to the Vision Provider.

F. Vision Providers may also call the IEHP Provider Relations Team at (909) 890-2054 and/or Medical Director for advice or consultation regarding Member ocular health issues, including diagnostic or treatment consultation, or the appropriateness of a referral.

Medications

A. IEHP covers medically necessary medications for the treatment of ocular disease as listed in the IEHP formulary.

INLAND EMPIRE HEALTH PLAN		
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12. COORDINATION OF CARE

M. Developmental Disabilities

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP and its IPAs have established procedures for the identification, referral and case management of Members identified with or suspected of having developmental disabilities to ensure their access to medically necessary screening, preventive, diagnostic, and treatment services.[1]

PROCEDURES:

Identification and Referral of Developmental Disability Cases

A. Members at risk for developmental disabilities may be identified through:
   1. Primary Care Provider (PCP) or Specialist referrals; or
   2. An IPA or IEHP Care Manager through:
      a. Screening of incoming California Children's Services (CCS) referrals;
      b. Review of hospital admission and discharge information;
      c. Member calls;
      d. IEHP Inland Regional Center (Regional Center) liaison; and
      e. IEHP Specialty Kids Intervention Team.

B. To qualify for Regional Center services, the Member's developmental disability must originate before their 18th birthday, be expected to continue indefinitely, and constitute a substantial disability.[2]

Provider and IPA Responsibilities

A. PCPs are required to provide all necessary primary care for individuals with developmental disabilities including:
   1. Well-child exams;
   2. Immunizations;
   3. Developmental status screening, illness or injury care;
   4. Diagnostic testing (laboratory, x-rays) as needed;

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 10, Services for Persons with Developmental Disabilities
[2] California Welfare and Institutions Code (Welf. & Inst. Code), § 4512

5. Health education as needed; and
6. Other primary care services as needed.

B. PCPs are required to arrange for and/or request from the Member's IPA all medically necessary specialty, diagnostic or therapeutic services, including out-of-network referrals, if a service is not available in-network.[3] If services are out-of-network, the IPA must send the referral to IEHP's UM Department for authorization. See Policy 14D, "Pre-Service Referral Authorization Process," for more information. These services include but are not limited to:

1. Referral to Specialist or sub-specialist Providers (e.g., Neurologists, Physiatrists);
2. Referrals for occupational or physical therapy;
3. Orders for medically necessary Durable Medical Equipment (DME) or home health services; and
4. Referrals for specialized diagnostic testing (e.g., computed tomography (CT) or Magnetic resonance imaging (MRI)).

C. IPA Care Managers are responsible for referring to the Regional Center, -Members in need of non-medical, home and community-based services such as:

1. Training in skills for daily living;
   a. Acquisition of skills and behavior and/or;
   b. Family support; and/or
   c. Day habilitation.
2. For all ages:
   a. Respite care; and/or
   b. ~~Residential care or a~~Assisted living.

D. PCPs, with assistance from IPA Care Managers, are responsible for assessing the behavioral health status of Members and referring those Medi-Cal Members with behavioral health disorders outside their scope of practice to the County Mental Health Plan.[4] Refer to Policy 12K1, "Behavioral Health - Behavioral Health Services," for more information.

E. PCPs or Obstetrics (OB) Providers who identify Members as being at risk of parenting a child with genetic disorders must provide counseling and referrals, as appropriate. Please see Policy 10D1, "Obstetric Services – Guidelines for Obstetrical Services" for more information.

[3] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 16, Out-of-Network Providers
[4] DHCS All Plan Letter (APL) 17-018 Supersedes APL 13-021, "Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services"

F. PCPs and Specialists are responsible for referring to the Regional Center Members under the age of 18 who may be potentially eligible for Home and Community-Based Services for the Developmentally Disabled (HCBS-DD) Waiver Program.[5]

G. IPAs and PCPs are responsible for assisting the family with referrals to the Regional Center's intake coordinator. The family must contact the Regional Center to initiate the intake process. For referral of children age 0 to 36 months, see Policy 12C, "Early Start Services and Referrals." Referrals include the following information:

1. The reason for referral;
2. The complete medical history and physical examination, including appropriate developmental screens;
3. The results of developmental assessment/psychological evaluation and other diagnostic tests as indicated; and
4. Individual Educational Plan (IEP), as appropriate.

H. Regional Center staff review the referral and notify the IPA, PCP and the Member, and Member's family or guardian when appropriate, regarding the Member's eligibility and recommendations for services.

Care Management

A. IEHP and its IPA Care Management (CM) teams coordinate services with Regional Center to achieve optimum outcomes for Members with developmental disabilities. IEHP's Regional Center liaison[6] and Specialty Kids Intervention Team assist as needed.[7]

B. IPA CM is responsible for performing the following activities:

1. Assisting the PCP with the referral to the Regional Center including arranging for transfer of medical information, approving medically necessary referrals and contact with the Regional Center;
2. Consulting with the PCP in the development of the individual care plan (ICP) for the Member;[8] and
3. Coordinating necessary follow-up between the PCP, Specialty Providers, IEHP, and the Regional Center to assure an organized care plan and delivery for the Member.

[5] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 10, Services for Persons with Developmental Disabilities
[6] Memorandum of Understanding (MOU) between IEHP and Inland Regional Center, Services for Developmentally Disabled Members, First Amendment, 01/01/21
[7] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 10, Services for Persons with Developmental Disabilities
[8] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 1, Comprehensive Case Management Including Coordination of Care Services

C. IPA CM remains responsible for providing care coordination and care management services for Members regardless of whether they receive services from Regional Center.

D. IEHP is responsible for providing assistance to the IPA CM or the Regional Center in complex or difficult cases or when differences arise regarding necessary services or care plans.

INLAND EMPIRE HEALTH PLAN		
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12. COORDINATION OF CARE

N. Multipurpose Senior Services Program

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP and its IPAs ensure access to and provision of Multipurpose Senior Services Program (MSSP) for Members who meet the following eligibility criteria:[1]

1. Medi-Cal Members who, but for the provision of such services, would require the Nursing Facility level of care;
2. Age 65 or older;
3. Able to be served within MSSP's cost limitations; and
4. Appropriate for care management services.

PURPOSE:

A. To promote identification and coordination of care for Members requiring services through the MSSP.

B. To ensure and support care coordination between IEHP and County agencies regarding Members' access to appropriate MSSP resources and focus on providing services in the least restrictive setting.

PROCEDURES:

MSSP Services

A. Long-Term Services and Supports (LTSS) includes a wide variety of services and supports that help eligible Members meet their daily needs for assistance and improve the quality of their lives. The MSSP program was approved under the federal Medicaid Home and Community-Based Services (HCBS), 1915(c) Waiver to provide HCBS to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement. MSSP services include:[2]

1. Case Management;
2. Personal Care and Chore Services;
3. Respite Care (in-home and out-of-home);
4. Environmental Accessibility Adaptations;

[1] Department of Health Care Services (DHCS) Medi-Cal Provider Manual, "Multipurpose Senior Services Program (MSSP)"
[2] Ibid.

5. Housing Assistance/Minor Home Repair, etc.;
6. Non-Medical Transportation;
7. Personal Emergency Response System /Communication Device;
8. Adult Day Care;
9. Protective Supervision;
10. Meal Services – Congregate/Home Delivered;
11. Social Reassurance/Therapeutic Counseling;
12. Money Management; and
13. Communication Services (such as translation/interpretation).

Identification of MSSP Cases

A. The Member's IPA performs care management activities and is responsible for assisting the PCP with identification and referral of Members to MSSP.

B. IEHP and its IPAs engage in outreach and case finding efforts to identify Members with potential MSSP program needs.

Referral of MSSP Cases

A. Referral and/or data sources may include but are not limited to the following:
   1. IEHP and/or IPA;
   2. Member and/or caregiver;
   3. PCP and/or Specialist;
   4. Member of Interdisciplinary Care Team (ICT);
   5. Medi-Cal and/or Health Plan utilization data;
   6. Health Risk Assessments;
   7. In-Home Supportive Services -Provider; or
   8. Community agency representative.

B. Referrals for MSSP can be received through the following mechanisms:
   1. Member and/or caregiver may self-refer by calling MSSP, IEHP or their IPA.
   2. Providers, IPAs, care managers, and community representatives can submit the Care Management (CM) Referral form requesting IEHP assistance to refer the Member to MSSP. The CM Referral form can be found on the IEHP website at: www.iehp.org, or on the secure IEHP Provider web portal (see Attachment, "IEHP Care Management Referral Form" in Section 25).

C. IEHP's Behavioral Health and Care Management (BH & CM) Team submits the referral to

the appropriate MSSP county agency on behalf of the IPA and communicates the referral outcome to IPA staff.

D. The MSSP county agency is responsible for all assessments and reassessments associated with authorizations of MSSP services.[3]

IEHP, IPA and Provider Responsibilities

A. IPA Care Manager assists the PCP with completing their MSSP referral through IEHP and follow up.

B. County MSSP agencies establish and maintain a wait list of individuals referred to MSSP. After the Member is placed on the MSSP wait list, the appropriate county MSSP agency provides IEHP with a list of Members on the wait list. IEHP's BH & CM Team shares the Member's status with the Member's IPA.

C. The IPA continues to provide care management services to Members placed on a county MSSP waiting list, including but not limited to coordinating available services and providing follow-up for Members.

D. Members not accepted into MSSP continue to receive medical care and care management services through their IPA and PCP.

E. Members authorized for MSSP services continue to receive medical services from IEHP.

F. IEHP or the IPA Care Manager coordinates and works collaboratively with MSSP county case managers on care coordination activities surrounding the MSSP Member including, but not limited to:

1. Coordination of benefits between IEHP and MSSP county case manager to avoid duplication of services;[4] and

2. Coordination of care management activities particularly at the point of discharge from the MSSP.

Interdisciplinary Care Team Case Conference

A. Members shall have access to an ICT case conference upon request or when there is a change in the care plan or significant change in the Member's health status.[5] Members and/or their caregivers may request an ICT case conference at any time by calling their IPA.

B. MSSP County Case Managers and PCPs may call an ICT case conference at any time to discuss the Member's needs by calling Provider Relations Team at (909) 890-2054. IEHP and its IPAs ensure the ability to facilitate and support a case conference.

[3] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 21, Provision 3, Utilization Management

[4] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 21, Provision 8, Coordination of Care.

[5] DHCS All Plan Letter (APL) 17-012 Supersedes 14-010, "Care Coordination Requirements for Managed Long-Term Services and Supports"

C. The IPA facilitates and supports an ICT to coordinate the delivery of services and benefits as needed for each Member.

D. The IPA Care Manager notifies the MSSP County Case Manager regarding the Member's scheduled ICT meeting and invites them to participate in the case conference.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2022

12. COORDINATION OF CARE

O. Open Access (Foster Care) Program

APPLIES TO:

A. This policy applies to IEHP Medi-Cal Foster Care Members that have been designated to participate in the Open Access program by either San Bernardino County Children and Family Services (CFS) or Riverside County Department of Public Social Services (DPSS).

POLICY:

A. IEHP provides needed health care services for youth in foster care who are enrolled in Open Access.[1,2]

PROCEDURES:

A. Only the Riverside County Department of Public Social Services (DPSS) or San Bernardino County Children and Family Services (CFS) can authorize a foster child to participate in IEHP's Open Access program.

B. Foster children who are not specifically authorized to participate in IEHP's Open Access program receive service as IEHP Medi-Cal Members.

C. Open Access Members are assigned to IEHP-Direct; therefore, IEHP retains responsibility for utilization management (UM) activities.

D. Open Access Members are automatically assigned to a participating Open Access Primary Care Provider (PCP); however, they may access care from any of the PCPs that participate in the Open Access Network. The Open Access PCP is reimbursed on a Fee-For-Service basis, per visit, for services.

E. If the Open Access Member is new to the PCP office, the PCP can access all known medical history from the secure IEHP Provider portal from the Medical History Profile with the following data (if available to IEHP):

   1. Encounter/claims data;
   2. Pharmacy data; and
   3. Immunization data.

F. IEHP has an Open Access Team that works with the Counties to coordinate the Members' care.

G. Referrals for services or procedures are sent to IEHP's UM department. See Policy 14D, "Pre-Service Referral Authorization Process" for further details regarding the referral process.

H. For anticipated invasive procedures or anticipated treatment with psychotropic medications

[1] Memorandum of Understanding (MOU) between IEHP and Riverside County Department of Public Social Services (DPSS), Open Access, 05/14/18
[2] MOU between IEHP and San Bernardino County Children and Family Services (CFS), Open Access, 02/01/10

the physician should:

1. Advise the Foster Parent at the time of the visit; and
2. Notify IEHP's Open Access Team at (800) 706-4347 who will then notify the DPSS or CFS.[3,4]

I. A court order is required for any invasive procedures, or when psychotropic medication is prescribed. IEHP will notify the county social worker and Foster Parent once a decision for requested services has been made.

J. For referral process information on Dental Services, Vision Services and Health Education please see the following Provider Manual policies:

1. Policy 12J, "Dental Services"
2. Policy 12L, "Vision Services"
3. Policy 15A, "Health Education"

~~K. Access to behavioral health and substance use services are coordinated through the Member's social services case worker.[5] Foster parents are instructed to call their social services case worker.~~

~~L.~~ Whenever a Provider has knowledge of or observes a child whom the Provider knows or reasonably suspects has been the victim of child abuse or neglect, the Provider must make an initial report by telephone to the appropriate agency immediately or as soon as is practicably possible. Please see Policy 10N, "Mandatory Child Abuse and Neglect Reporting," for more information on reporting known or suspected cases of child abuse or neglect.

~~M.~~K. ~~Please see~~See Section 20, "Claims Processing" for information on submission of claims for Open Access Members.

[3] MOU between IEHP and Riverside County DPSS, 05/14/18
[4] MOU between IEHP and San Bernardino County CFS, 02/01/10
[5] ~~California Welfare and Institutions Code (Welf. & Inst. Code), § 16501.4~~

12. COORDINATION OF CARE

O. Open Access (Foster Care) Program

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	August 1, 2007
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, ~~2022~~2023

12. COORDINATION OF CARE

P. Home and Community-Based Alternatives Waiver Program

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP and its IPAs have established processes to identify and refer Members who may benefit from Home and Community-Based Services (HCBS) waiver programs, including but not limited to Home and Community-Based Alternatives (HCBA) waiver program (formerly known as the Nursing Facility/Acute Hospital Waiver) to the appropriate agency.[1]

PROCEDURES:

HCBA Waiver Program

A. The HCBA Waiver Program is for Members who are at risk or require care for ninety (90) consecutive days or greater in an inpatient skilled nursing facility (SNF). The goals of the waiver program are to:[2,3]

   1. Facilitate a safe and timely transition of Medi-Cal eligible Members from a medical facility to their home and community utilizing HCBA Waiver services; and

   2. Offer eligible Members who reside in the community but are at risk of being institutionalized within the next thirty (30) days, the option of utilizing the HCBA Waiver services to develop a home program that will safely meet their medical care needs.

B. The HCBA Waiver Program provides in-home care to Members as an alternative to institutionalization.[4] Services are available to Members with physical disabilities or Members who meet the acute hospital, adult or pediatric sub-acute, nursing facility, distinct-part nursing facility, adult or pediatric Level B (skilled) nursing facility, or Level A (intermediate) nursing facility (NF) Level of Care.[5]

C. This program is intended to support Members with the option of returning to and/or remaining in their home or home-like setting in the community in lieu of institutionalization. Services may include, but are not limited to:[6]

   1. Private Duty Nursing, including shared nursing;

   2. Home Health Aide Services;

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 21, Waiver Programs
[2] Section 1915(c) Home and Community-Based Services (HCBS) Waiver, 01/01/20
[3] DHCS Medi-Cal Provider Manual, HCBS.
[4] Ibid.
[5] Section 1915(c) HCBS Waiver, 01/01/20
[6] Ibid.

3. Case Management and Transitional Case Management;
4. Family and caregiver training;
5. Environmental accessibility adaptations;
6. Personal emergency response systems, including installation and training;
7. Medical equipment operating expenses;
8. Waiver personal care services;
9. Community transition;
10. Habilitation services;
11. Respite care (home and facility); and
12. Developmentally disabled/continuous nursing care (non-ventilator and ventilator dependent services).

D. A Member may be enrolled in only one (1) HCBS Waiver program at a time.[7]

Member Identification and Referral

A. Primary Care Providers (PCPs) or Specialists are responsible for the identification of Members potentially eligible for the HCBA Waiver Program.

B. The Provider identifies Members with potential HCBA Waiver Program needs. Criteria for eligibility include:[8]

1. Must have full scope Medi-Cal;
2. Physically disabled (no age limit);
3. Must meet the acute hospital, adult or pediatric sub-acute, nursing facility, distinct-part nursing facility, adult or pediatric Level B (skilled) nursing facility, Level A (intermediate) nursing facility Level of Care with the option of returning to and/or remaining in his/her home or home-like setting in the community in lieu of hospitalization; and
4. Must meet other criteria and requirements listed in the waiver.

C. IEHP and its IPAs are responsible for assisting Providers with the identification and referral of Members to the HCBA Waiver Program.

D. The Provider, with the assistance from IEHP or their IPA, submits applicable medical records and a request for HCBA Waiver services to the Institute on Aging:[9]

1. By fax: (909) 284-8002

[7] DHCS Medi-Cal Provider Manual, HCBS
[8] Ibid.
[9] https://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx

2. By efax: eFaxCLS-IE-HCBA@ioaging.org
3. On the website: www.ioaging.org

Case Management

A. When requested by the treating Provider, the Member's IPA Care Manager assists in coordinating available services and providing follow-up for Members requiring referral to the HCBA Waiver Program through the following methods:
   1. Maintenance of continuity of care through coordination with case managers from the Institute on Aging;
   2. Coordination with the PCP to ensure that medically necessary health care services are provided until transfer to the HCBA Waiver Program services is completed; and
   3. Maintenance of a continuous and unimpeded flow of medical information between Providers.

B. IEHP is available to assist the IPA Care Managers with care management activities through the following methods:
   1. Identification of appropriate community referral sources available to Members; and
   2. Assistance with eligibility questions, coordination of care assistance and other questions.

C. The Provider continues to provide medical care for the Member until transfer to the HCBA Waiver Program has been completed. Members not accepted into the HCBA Waiver Program continue to receive medical care through their Provider and continue to receive services from the IPA Care Manager.

D. Members are not disenrolled from IEHP when placed on HCBA waiver.[10] The Provider will continue to be involved, especially the PCP who will work directly with the home health agencies and/or other community providers.

INLAND EMPIRE HEALTH PLAN		
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Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2021

[10] DHCS Medi-Cal Provider Manual, HCBS

12. COORDINATION OF CARE

P. Home and Community-Based Alternatives Waiver Program

12. COORDINATION OF CARE

Q. AIDS Medi-Cal Waiver Program

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP, IPAs, Primary Care Providers (PCPs), and Specialists are responsible for the identification of candidates potentially eligible for the Acquired Immune Deficiency Syndrome (AIDS) Medi-Cal Waiver Program.

B. IEHP and its IPAs perform care management activities and are responsible for assisting Providers with identification and referral of Members to the AIDS Medi-Cal Waiver Program.

PROCEDURES:

AIDS Medi-Cal Waiver Program

A. The AIDS Medi-Cal Waiver Program provides in-home and community-based services to Members with AIDS or related diseases as an alternative to institutionalized care. Services include:[1]

1. Care management;
2. In-home skilled nursing care;
3. Attendant and homemaker care;
4. Psychosocial counseling;
5. Equipment and minor physical adaptations to the home;
6. Medi-Cal supplements for infants and children in foster care;
7. Non-emergency medical transportation;
8. Nutritional counseling and supplements;
9. Home-delivered meals and administrative expenses.

B. Providers, IPAs and IEHP identify Members with potential AIDS Medi-Cal Waiver Program needs. Criteria for eligibility include:[2]

1. Diagnosis of AIDS or symptomatic HIV disease; and
2. Medi-Cal eligibility.

Referral Process

A. The Provider, IPA or IEHP obtains a written consent for referral from eligible Members. The

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 02-001, "Medi-Cal HIV/AIDS Home and Community Based Services Waiver Program"
[2] Ibid.

referring party is responsible for completion of the Desert AIDS Project Enrollment Form (See Attachment, "Desert AIDS Project Enrollment Form" in Section 12) and submission of a request for services to local AIDS Projects at the following location:

Desert AIDS Project

(760) 323-2118 (Palm Springs)

~~(760) 342-4197 (Indio)~~

~~C.~~B. The AIDS Project sends information materials including agreement and consent forms to the Member. Once eligibility is established and the request for services is approved, the AIDS Project case managers assist with coordinating available services.

IPA and Provider Responsibilities

A. The Member's IPA Care Manager assists the treating Provider in coordinating available services and providing follow-up for Members requiring referral through the following methods:

1. Assistance with eligibility questions and completion of the referral;
2. Provision of telephonic monitoring of potential high-risk Members;
3. Maintenance of continuity of care through coordination with AIDS Project case managers;
4. Coordination with the PCP to ensure that all medically necessary health services are provided to the Member except for those services covered under the AIDS Medi-Cal Waiver Program; [3,4] and
5. Maintenance of a continuous and unimpeded flow of medical information between Providers. The PCP obtains medical records of health services provided.

B. IEHP is available for assistance with identification of appropriate community referral sources available to Members and other questions or difficulties regarding the AIDS Medi-Cal Waiver Program, as well as care coordination.

C. Members not accepted into the AIDS Medi-Cal Waiver Program continue to receive medical care and case management through the Provider and their IPA Care Managers.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revision Date:**	

[3] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 14, Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)
[4] DHCS APL 02-001

		January 1, ~~2022~~2023

12. COORDINATION OF CARE

Attachments

DESCRIPTION	POLICY CROSS REFERENCE
6 Months and Exit Progress Report Template	12K3
ABA Service Hour Log	12K3
~~AUDIT-C~~	~~12K2~~
BHT FBA Report Template	12K3
BHT Social Skills Template	12K3
~~Brief Addiction Monitor (BAM) With Scoring & Clinical Guidelines~~	~~12K2~~
CCS-GHPP Client Service Auth Request - Established Case	12B
CCS-GHPP Client Service Auth Request - New Case	12B
Desert AIDS Project Enrollment Form	12Q
GHPP Application to Determine Eligibility	12E
IEHP Lab Order Form	12L
In School BHT Services Request Form	12K3
~~Early Start Program Referral Form~~	~~12C~~
Medi-Cal FFS-Approved Transplant Center of Excellence	12G
~~Non Covered Services Waiver Form – English~~	~~12L~~
~~Non Covered Services Waiver Form – Spanish~~	~~12L~~
Ophthalmologist Referral Form	12L2
PCP Vision Report Form	12L2
~~6 Months and Exit Progress Report Template~~	~~12K3~~
Transplant Team Referral Form	12G

12. COORDINATION OF CARE

Attachments

Inland Empire Health Plan
Behavioral Health Treatment Progress Report
6-Month Report/Exit Report

PLEASE SELECT THE REPORT TYPE: _____ 6-Month _____ Exit

I. GENERAL INFORMATION:

First Name:		**Last Name:**	
Birth Date:		**IEHP Member ID#:**	
Present Address:			
Parent/Guardian:		**Phone:**	
Language:		**Reporting Period:**	XX/XX/XX - XX/XX/XX
Report Date:		**Program Supervisor:**	

II. SESSION INFORMATION:

Within the section and using the table below, Provider will list the treatment period months (see example) in the top box of each column. Provider will provide the number of sessions, number of direct treatment hours, number of supervision hours provided to the member each month, number of treatment sessions canceled by the Member and the number of treatment sessions canceled by the Provider. Provider will provide a narrative on any barriers to providing treatment to the Member within this section; this will include frequent cancelations, late starts, staff turnover, etc.

Behavior Health Treatment	Jan	Feb	Mar	Apr	May	Jun	Total
# of Treatment Sessions:							
# of treatment Sessions							
# of Supervision hours							
# of Sessions Canceled by Member							
# of Sessions Canceled by Provider							

III. BACKGROUND INFORMATION: UPDATE ANY INFORMATION FROM THE INITIAL ASSESSMENT OR PREVIOUS REPORTING PERIOD.

a. Living Situation-

Within this section describe where and with whom the Member lives (include any custody/visitation orders, childcare arrangements).

b. School Information-

Within this section list the Member's school information: Grade Level, School placement (e.g., General Education Class, Specialized Academic Support, Autism Program, Mild/Moderate, Moderate/Severe, or Non-Public School), School name, School attendance days and hours, frequency and duration of related services provided by the school district (e.g., Occupational therapy, Speech Therapy, Physical Therapy, Adaptive Physical Education, Counseling, Nursing, Applied Behavior Analysis).

c. Health and Medical-

Within this section Provide the Member's psychological and medical diagnoses (include when and who provided the diagnoses). Describe the Member's birth history, major illness, surgeries, hospitalizations, seizure history, allergies, hearing and vision screening results, vaccination, specialized diet or food consumption challenges, sleep difficulties. Include a list of medications and their relevance to behavior services.

d. Current Services and Activities-

Within this section list the weekly frequency and duration of all services funded by insurance (e.g., OT, ST, PT, Social Skills) and Inland Regional Center (e.g., Infant Stimulation, Respite, Adaptive Skills, Day Program). Additionally, include any weekly activities the Member participates in (e.g., Boy/Girl Scouts, Baseball, Basketball, Soccer, Dance/Gymnastics, Art therapy, etc.).

IV. SUMMARY OF PROGRESS:

Within the summary of progress section, the provider will need to provide a narrative on the Member's overall treatment progress during the current reporting period. Summary of progress will need to include the following information:

- % of current treatment plan goals mastered during the reporting period.
- % of current treatment plan goals that the Member is making progress toward.
- Explain how the Member has responded to treatment with the Provider.

V. BARRIERS TO PROGRESS:

Within the barriers to progress section, the Provider will include information on any or all barriers to the Member's progress (e.g., frequent cancellations, illness, vacations, etc.). The provider will need to include any action plans or actions take to address the outlined barriers to progress. If no barriers exist, the Provider will need to make a statement that there are no barriers to the delivery of service at this time.

(Insert page break)

VI. ASSESSMENT MEAURES:

Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)
Milestones Scoring Form

Child's name:	
Date of birth:	
Age at testing:	

Key:	Score	Date	Color	Tester
1st test:				
2nd test:				
3rd test:				
4th test:				

LEVEL 3

	Mand	Tact	Listener	VP/MTS	Play	Social	Reading	Writing	LRFFC	IV	Group	Ling.	Math
15													
14													
13													
12													
11													

LEVEL 2

	Mand	Tact	Listener	VP/MTS	Play	Social	Imitation	Echoic	LRFFC	IV	Group	Ling.
10												
9												
8												
7												
6												

LEVEL 1

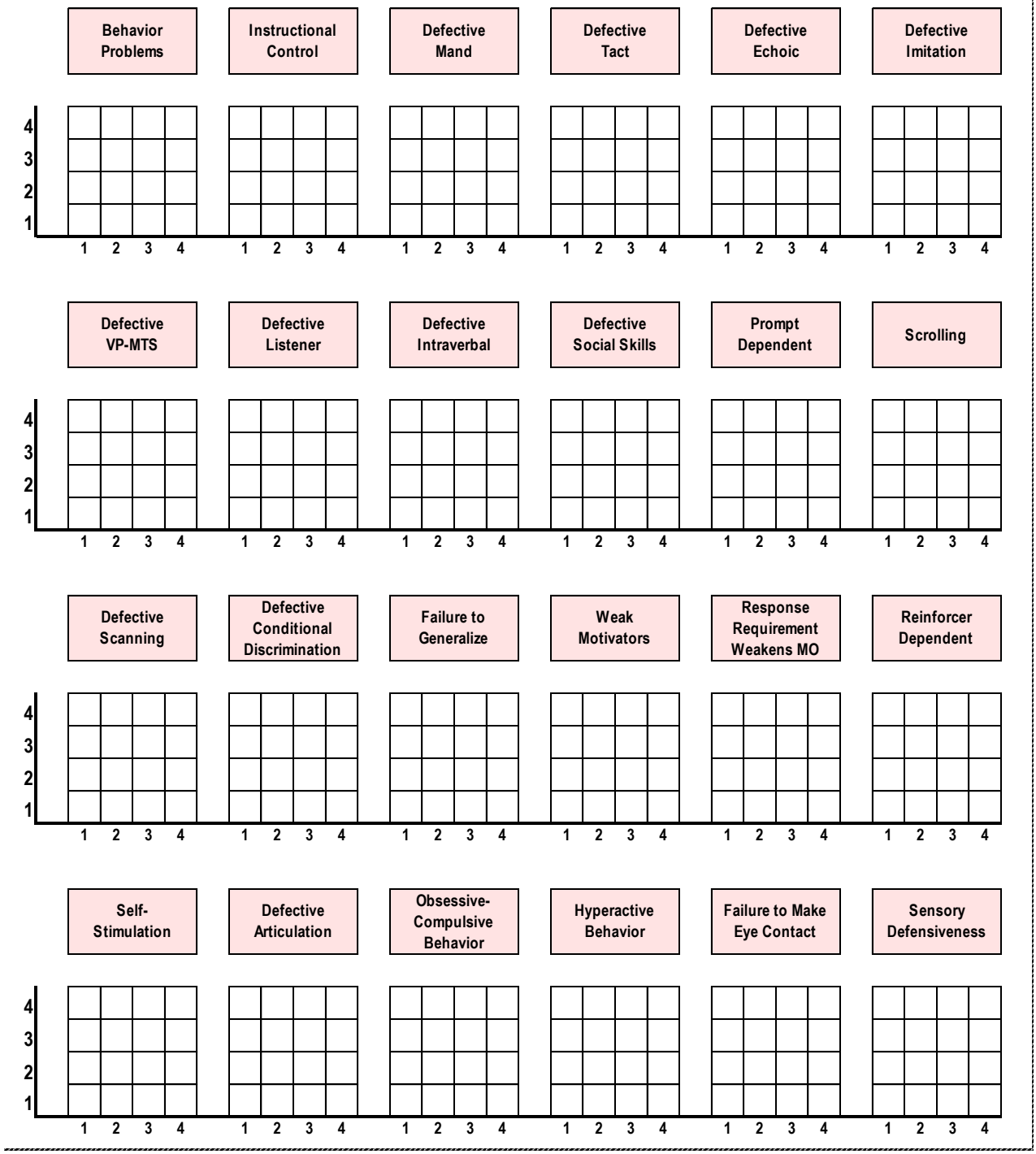
	Mand	Tact	Listener	VP/MTS	Play	Social	Imitation	Echoic	Vocal
5									
4									
3									
2									
1									

(Insert page break)

VB-MAPP Barriers to Learning

Child's name:	
Date of birth:	
Age at testing:	1 2 3 4

Key:	Score	Date	Color	Tester
1st test:				
2nd test:				
3rd test:				
4th test:				



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REPORT DATE: XX/XX/XXXX **IEHP ID:** XXXXXXXXXXX

Vineland Adaptive Behavior Scales, 2nd Edition

Date Administered: XX/XX/XXXX

Name of Interview: First Name/Last Name, Credentials

Name of Respondent: First Name/Last Name, relationship

Assessment Summary:

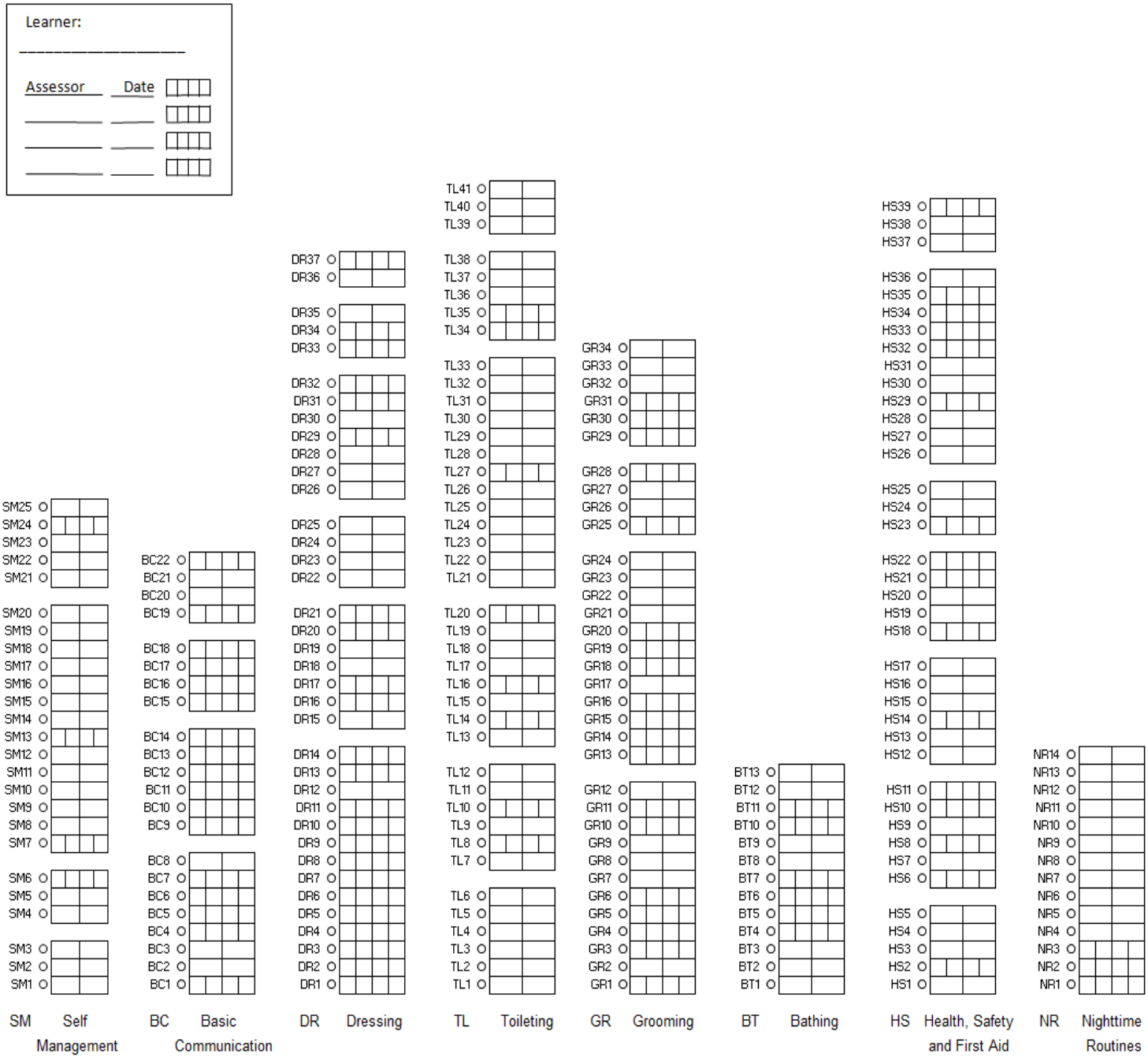
Write a brief narrative about the results and include the following in a paragraph:

- If there are significant differences between what is reported by the respondent to your observations, note that tactfully
- Note the Adaptive Behavior Composite score from last year and any significant changes with the results since then
- Refer the reader to reference last year's report for full Vineland scores

Domain	Standard Score*	95% Confidence Interval**	Age Equivalent***	Adaptive Level****
Communication				
Receptive			3 years, 5 months	
Expressive				
Daily Living Skills				
Personal				
Domestic				
Community				
Socialization				
Interpersonal Relationships				
Play and Leisure Time				
Coping Skills				
Motor Skills				
Gross Motor				
Fine Motor				
Adaptive Behavior Composite				

(Insert page break)

Assessment of Functional Living Skills (AFLS)
Basic Skills/Community Participation/Home Skills



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REPORT DATE: XX/XX/XXXX **IEHP ID:** XXXXXXXXXXXX

Adaptive Behavior Assessment System, Third Edition (ABAS-3)

Date Administered: XX/XX/XXXX

Name of Interview: First Name/Last Name, Credentials

Name of Respondent: First Name/Last Name, relationship

Age: XX years, XX months

Age at Testing: XX years, XX months

Assessment Summary:
Write a brief narrative about the results and include the following in a paragraph:

Skill Area	Raw Score	Scaled Score	Description
Communication			
Community Use			
Functional Academics			
Home Living			
Health and Safety			
Leisure			
Self-Care			
Self-Direction			
Social			
Work			

(Insert page break)

VII. Program Goals

Within the program goals section of the progress report, the Provider will report on the progress from the treatment goals outlined from the Functional Behavior Assessment. Graphs need to be included for each treatment goal. Line Percentage Graphs should not have more than 3 data paths on a single graph. Providers are encouraged to use cumulative graphs for accusation treatment goals that have many program targets. Graphs should include the following elements:

- The height of Graphs should be no larger than 3''
- Graphs should be aligned left
- Graph Title should match the name of the Goal
- Y & X axis should correlate with data collection procedure and information reported.
- Breaks in data path should include a textbox explaining the break in data.
- All phase change lines have been inserted and labeled

1. Behavior:

1. **Program Name:** Title of program being targeted – **(Introduced XX/XX/XXXX) (On Hold XX/XX/XXXX)**
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.
Progress: In Progress/Goal Met/On Hold/Modified/In Maintenance/Discontinued – Include specific information about progress made towards this goal, which may include: Each goal should include a brief narrative on mastered program targets, current program targets in acquisition, the prompting and fading procedures utilized during the reporting period, and the teaching plan for the upcoming reporting period.

(Insert graph – align left on the page)

Revised Goal **(When Modifying/Revising a Goal use the title Revised Goal with the revised goal and progress)**
2. **Program Name:** Title of program being targeted – **(Introduced XX/XX/XXXX)**
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.
Progress: In Progress/Goal Met/On Hold/Modified/In Maintenance/Discontinued – Include specific information about progress made towards this goal, which may include: Each goal should include a brief narrative on mastered program targets, current program targets in acquisition, the prompting and fading procedures utilized during the reporting period, and the teaching plan for the upcoming reporting period.

(Insert graph – align left on the page)

New Goal(s) (When adding a new Goal within this section use the title New Goal(s) with the new goal)

3. **Program Name:** Title of program being targeted
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

2. Communication:

4. **Program Name:** Title of program being targeted – **(Introduced XX/XX/XXXX) (On Hold XX/XX/XXXX)**
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.
Progress: In Progress/Goal Met/On Hold/Modified/In Maintenance/Discontinued – Include specific information about progress made towards this goal, which may include: Each goal should include a brief narrative on mastered program targets, current program targets in acquisition, the prompting and fading procedures utilized during the reporting period, and the teaching plan for the upcoming reporting period.

(Insert graph – align left on the page)

Revised Goal (When Modifying/Revising a Goal use the title Revised Goal with the revised goal and progress)

5. **Program Name:** Title of program being targeted – **(Introduced XX/XX/XXXX)**
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.
Progress: In Progress/Goal Met/On Hold/Modified/In Maintenance/Discontinued – Include specific information about progress made towards this goal, which may include: Each goal should include a brief narrative on mastered program targets, current program targets in acquisition, the prompting and fading procedures utilized during the reporting period, and the teaching plan for the upcoming reporting period.

(Insert graph – align left on the page)

New Goal(s) (When adding a new Goal within this section use the title New Goal(s) with the new goal)

6. **Program Name:** Title of program being targeted
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

3. Self-Help:

7. **Program Name:** Title of program being targeted – **(Introduced XX/XX/XXXX) (On Hold XX/XX/XXXX)**
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.
Progress: In Progress/Goal Met/On Hold/Modified/In Maintenance/Discontinued – Include specific information about progress made towards this goal, which may include: Each goal should include a brief narrative on mastered program targets, current program targets in acquisition, the prompting and fading procedures utilized during the reporting period, and the teaching plan for the upcoming reporting period.

(Insert graph – align left on the page)

Revised Goal (When Modifying/Revising a Goal use the title Revised Goal with the revised goal and progress)

8. **Program Name:** Title of program being targeted – **(Introduced XX/XX/XXXX)**
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.
Progress: In Progress/Goal Met/On Hold/Modified/In Maintenance/Discontinued – Include specific information about progress made towards this goal, which may include: Each goal should include a brief narrative on mastered program targets, current program targets in acquisition, the prompting and fading procedures utilized during the reporting period, and the teaching plan for the upcoming reporting period.

(Insert graph – align left on the page)

New Goal(s) (When adding a new Goal within this section use the title New Goal(s) with the new goal)

9. **Program Name:** Title of program being targeted
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

4. Social Skills:

10. **Program Name:** Title of program being targeted – **(Introduced XX/XX/XXXX) (On Hold XX/XX/XXXX)**
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.
Progress: In Progress/Goal Met/On Hold/Modified/In Maintenance/Discontinued – Include specific information about progress made towards this goal, which may include: Each goal should include a brief narrative on mastered program targets, current program targets in acquisition, the prompting and fading procedures utilized during the reporting period, and the teaching plan for the upcoming reporting period.

(Insert graph – align left on the page)

Revised Goal (When Modifying/Revising a Goal use the title Revised Goal with the revised goal and progress)

11. **Program Name:** Title of program being targeted – **(Introduced XX/XX/XXXX)**
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.
Progress: In Progress/Goal Met/On Hold/Modified/In Maintenance/Discontinued – Include specific information about progress made towards this goal, which may include: Each goal should include a brief narrative on mastered program targets, current program targets in acquisition, the prompting and fading procedures utilized during the reporting period, and the teaching plan for the upcoming reporting period.

(Insert graph – align left on the page)

New Goal(s) (When adding a new Goal within this section use the title New Goal(s) with the new goal)

12. **Program Name:** Title of program being targeted

Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)

Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)

Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)

Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)

Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

5. Parent Education:

1. **Parent Goal Domain:** Title of Domain being targeted

Instrumental Goal: Objective of the program (make sure this is measurable, objective, and specific) include data collection procedure and mastery criteria.

Baseline: Include a brief statement about the Member's Parent's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

Progress: In Progress/Goal Met/On Hold/Terminated – Include specific information about progress made towards this goal.

2. **Parent Goal Domain:** Title of Domain being targeted

Instrumental Goal: Objective of the program (make sure this is measurable, objective, and specific) include data collection procedure and mastery criteria.

Baseline: Include a brief statement about the Member's Parent's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

Progress: In Progress/Goal Met/On Hold/Terminated – Include specific information about progress made towards this goal.

VIII. Target Behaviors

Behavior #1 (Insert Behavior Name)

Information here is taken from the FBA. NEW identified behaviors need to follow FBA template format. Each identified behavior needs to have a reduction and replacement goal.

a. **Topography of Behavior:** Operational definition of the target behavior. The definition will be observable, measurable, and objective. (Based on this technological description all individuals will be able to easily recognize and record behavior). Definition should include criteria regarding what is and is not counted as the target behavior (e.g., duration, severity, instances vs. episodes, etc.).

b. **Onset/Offset:** Statement regarding when the behavior begins and ends.

c. **Course of Behavior:** Describe whether or not the behavior occurs across (persons, places, and times of the day). List any escalation patterns and/or cycles. Describe how the behavior typically subsides.

d. **Baseline Data:** Insert baseline data for target behavior.

IX. Behavior Intervention Plan (Updated as of XX-XX-XXXX)

The behavior intervention plan is taken from the initial FBA and needs to be updated on an ongoing basis. The intervention plan needs to be individualized and written in a technological manner.

a. Ecological Strategies- *Within this section of the behavior intervention plan describe all ecological strategies used.* ***Strategies should be written technological***

b. Antecedent Based Intervention Strategies- *Within this section of the behavior intervention plan describe all antecedent interventions used.* ***Strategies should be written technological. Examples include but not limited to:*** *Visual schedules, priming, clear expectations, first/then contingency training, structured choices, etc.*

c. Reactive/Consequence Based Intervention Strategies- *Within this section of the behavior intervention plan describe all consequence interventions used.* ***Strategies should be written technological. Examples include but not limited to: redirection, extinction, differential reinforcement, etc.***

d. Safety Procedure- *Within this section please provide safety procedures used to keep the Member and other's safe during crisis situations, extinction bursts, and behavior escalation. This can include any special instructions from the QASP's adoptive Crisis Prevention Training Programs (e.g., Nonviolent Crisis Intervention, Safety-Care Behavioral Safety, Professional Crisis Management, or Professional Assault Crisis Training).*

X. **Teaching Intervention Strategies-** *Within this section list all teaching procedures and methodologies used to ~~the~~ teach skill deficits and replacement behaviors. Include strategies on generalization, maintenance, thinning schedules of reinforcement, transition to natural mediators, and relapse prevention.*

XI. Family Involvement: *Within this section of the report Provider will outline parent involvement and participation within the therapy session. Provider will include statement on the expected level of participation as outlined within the Behavioral Health Treatment IEHP Policy. Provider will parent training approach and education. Parent education goals will be listed below.* ***Parent Participation is not an education goal, it is an expectation.***

XII. Location of Service: *Include a description on where services will take place.* **Provider may not provide services in the school setting, day care, or other locations in which parent or caregiver is not present, unless prior authorization is given by the health plan.**

XIII. Coordination of Care: *Include a description on how the treatment team assigned to the Member's case will work* collaboratively with, *their school, Behavioral Health professionals and* other health care professionals involved in the care of a Member (e.g., PCP, OT, SLP).

XIV. Discharge Criteria: *Within this section include a description regarding the discharge criteria and transition of care. Transition of care should include Member aging out of BHT services at the age of 21. Authorizations for BHT will not extend past the Member's 21st birthday. For Members who are within sixty (60) days of their 21st birthday,*

the BHT Provider must initiate the transition process to an alternative funding source (e.g., Regional Center, County Services, or Department of Rehabilitation).

XV. Recommendations: *Within this section provide a summary of the clinical recommendations for the Member. This should include the rational for* ***MEDICALLY NECESSARY*** *behavioral health treatment. The rate of supervision provided by the QAS Professional and/or QAS Provider to the QAS Paraprofessionals will be based on a ratio of 2 hours of supervision service per every 10 hours of direct service authorized, unless the case calls for increased supervision as agreed by QAS Provider and IEHP Health Plan.* ***Providers requesting additional supervision beyond standard ratios and guidelines will need to include clinical justification on the need for enhanced supervision***

Report completed by:

SIGNATURE REQUIRED

Name
Title
Agency Name

Date:

Report reviewed and approved by: ***The Health plan requires a second review by BCBA***

SIGNATURE REQUIRED

Name
Title
Agency Name

Date:

Inland Empire Health Plan

Behavioral Health Treatment
Page 1 of 2

Authorization #: ______________________________

Member Name: ______________________________ **Member Identification Number:** ____________________________

Qualified Autism Service Provider Name: ____

NPI #: __________________________ **Provider Phone #:** ( ) ________________________________

Services Provided: **Month** __________________ **Year** ______________

Date:	Location:	Name & Credential of Person Providing Services	CPT Code:	Start Time	End Time	Total Time:	Parent/Guardian Signature
		NPI #: _ _ _ _ _ _ _ _ _ _ _					
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Date:	Location:	Name & Credential of Person Providing Services	CPT Code:	Start Time	End Time	Total Time:	Parent/Guardian Signature
		NPI #: _ _ _ _ _ _ _ _ _ _ _					
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I verify that the Behavioral Health Treatment provided by the Qualified Autism Service Provider to my child is listed on this form true, correct, and complete.

____
Parent/Guardian Printed Name:

____
Parent/Guardian Signature:

Inland Empire Health Plan
Functional Behavioral Assessment Report
Intervention Plan

I. GENERAL INFORMATION:

First Name:		**Last Name:**	
Birth Date:		**IEHP Member ID#:**	
Present Address:			
Parent/Guardian:		**Phone:**	
Language:		**Referral Date:**	
Report Date:		**Assessor/Certification:**	

II. PRESENTING CONCERNS:

Write a brief description regarding the presenting concerns and why the Member is seeking services from your agency.

III. BEHAVIORS:

The behaviors and functional skills to be addressed are:

- ☐ Non-Compliance
- ☐ Physical Aggression
- ☐ Verbal Aggression
- ☐ Tantrums
- ☐ Yelling/Screaming
- ☐ Property Destruction
- ☐ Self-injury
- ☐ Elopement
- ☐ Stereotypic Behavior
- ☐ Smearing
- ☐ PICA
- ☐ Self-Help Skills
- ☐ Functional Communication
- ☐ Self-Direction
- ☐ Social Skills
- ☐ Hygiene
- ☐ Toilet Training
- ☐ Independent Living Skills
- ☐ Safety Awareness
- ☐ Food Selectivity
- ☐ Other: _____

IV. BACKGROUND INFORMATION:

a. Living Situation-

Within this section describe where and with whom the Member lives (include any custody/visitation orders, childcare arrangements).

b. School Information-

Within this section list the Member's school information: Grade Level, School placement (e.g., General Education Class, Specialized Academic Support, Autism Program, Mild/Moderate, Moderate/Severe, or Non-Public School), School name, School attendance days and hours, frequency and duration of related services provided by the school district (e.g., Occupational therapy, Speech Therapy, Physical Therapy, Adaptive Physical Education, Counseling, Nursing, Applied Behavior Analysis).

c. Health and Medical-

Within this section Provide the Member's psychological and medical diagnoses (include when and who provided the diagnoses). Describe the Member's birth history, major illness, surgeries, hospitalizations, seizure history, allergies, hearing and vision screening results, vaccination, specialized diet or food consumption challenges, sleep difficulties. Include a list of medications and their relevance to behavior services.

d. Current Services and Activities-

Within this section list the weekly frequency and duration of all services funded by insurance (e.g., OT, ST, PT, Social Skills) and Inland Regional Center (e.g., Infant Stimulation, Respite, Adaptive Skills, Day Program). Additionally, include any weekly activities the Member participates in (e.g., Boy/Girl Scouts, Baseball, Basketball, Soccer, Dance/Gymnastics, Art therapy, etc.).

e. Intervention History-

Within this section list discuss the Member's intervention history. This includes services received during 0-3 (infant program), ABA services received through regional center or private insurance, social recreation/community integration adaptive skills training speech therapy, occupational therapy, and physical therapy. (List the weekly frequency and duration, the length of time the Member received the therapy and the provider/agency that provided the services).

f. Availability for Behavior Health Treatment Services-

Within this section list the Member's availability to participate in the BHT services.

V. MEMBER'S ENVIRONMENTAL ANALYSIS:

Availability and Access to reinforcers:	☐ Yes	☐ No	
Availability of developmental toys/materials:	☐ Yes	☐ No	
Availability of visual schedules/timers:	☐ Yes	☐ No	
Opportunities for activities throughout the day:	☐ Yes	☐ No	
Opportunities for social interaction:	☐ Yes	☐ No	
Will parent's schedule allow for treatment involvement?	☐ Yes	☐ No	
Appropriate space available for conducting sessions?	☐ Yes	☐ No	
Environment Conducive to QASP Policy on Cleanliness?	☐ Yes	☐ No	
Level of noise/Environmental Distractions:	☐ None	☐ Fair	☐ High

VI. DESCRIPTION OF ASSESSMENT PROCEDURES:

Procedures:	Date and Location:	Person involved (indicate credentials):
☐ Records Reviewed:		
☐ Clinical Interview:		
☐ 1st Member Observation:		
☐ 2nd Member Observation:		
☐ Brief Functional Analysis:		

Stimulus Preference Assessments:	Date(s) Administered:
☐ Free Operant Observations	
☐ Single Stimulus	
☐ Paired Stimulus	
☐ Multiple Stimulus with Replacement (MSW)	
☐ Multiple Stimulus without Replacement (MSWO)	
☐ Structured Interview (RAISD)	
☐ Checklist	

Assessment Measures Administered:	Date(s) Administered:
☐ Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)	
☐ Vineland Adaptive Behavior Scales, 2nd Edition	
☐ Adaptive Behavior Assessment System, 3rd Edition	
☐ Assessment of Functional Living Skills (AFLS)	

Indirect Functional Analysis Tools Used:	Date(s) Administered:
☐ Functional Assessment Screening Tool (FAST)	
☐ Motivation Assessment Scale (MAS)	
☐ Questions About Behavior Function (QABF)	

a. ***Records reviewed included:*** *Within this section of the report, include any records reviewed (examples: Individual Program Plan (IPP), Psycho-Diagnostic Evaluation (PDE), Early Start Report, Functional Behavior Assessment, Intensive Intervention Progress Report, Individual Education Plan (IEP), etc.). Report title, report date and report author information are required for each document reviewed.*

Records reviewed included:
Example:
1. ***Psycho-Diagnostic Evaluation*** (Report Author, XX/XX/XXXX).

b. ***Clinical Interview-*** *Within this section the assessor will narrate the date, time, location, and persons involved in the clinical interview. The assessor will write a summary of parental concerns (examples: challenging behaviors and skill deficits).*

c. ***First Member Observation-*** *Within this section the assessor will narrate the date, time, location, and persons involved in the first observation of the Member. The assessor will briefly describe significant events (e.g., skill observations, direct observation of behavior occurrence) pertaining to the Member's challenging behaviors.* ***Narrative should not exceed 500 words.***

d. ***Second Member Observation-*** *Within this section the assessor will narrate the date, time, location, and persons involved in the ~~first~~ second observation of the Member. The assessor will briefly describe significant events (e.g., skill observations, direct observation of behavior occurrence) pertaining to the Member's challenging behaviors.* ***Narrative should not exceed 500 words.***

e. ***Preference Assessment-*** *Within this section the assessor will state the preference assessment administered to the Member during the assessment.*

Preference Areas:	**Potential Reinforcers:**
☐ Social	
☐ Sensory	
☐ Toys or Activities	
☐ Food	

f. ***Limited Reinforcers-*** *Within this section the assessor will list any reinforcement restrictions or limitation.*

VII. ASSESSMENT MEAURES:

Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)
Milestones Scoring Form

Child's name:	
Date of birth:	
Age at testing:	

Key:	Score	Date	Color	Tester
1st test:				
2nd test:				
3rd test:				
4th test:				

LEVEL 3

	Mand	Tact	Listener	VP/MTS	Play	Social	Reading	Writing	LRFFC	IV	Group	Ling.	Math
15													
14													
13													
12													
11													

LEVEL 2

	Mand	Tact	Listener	VP/MTS	Play	Social	Imitation	Echoic	LRFFC	IV	Group	Ling.
10												
9												
8												
7												
6												

LEVEL 1

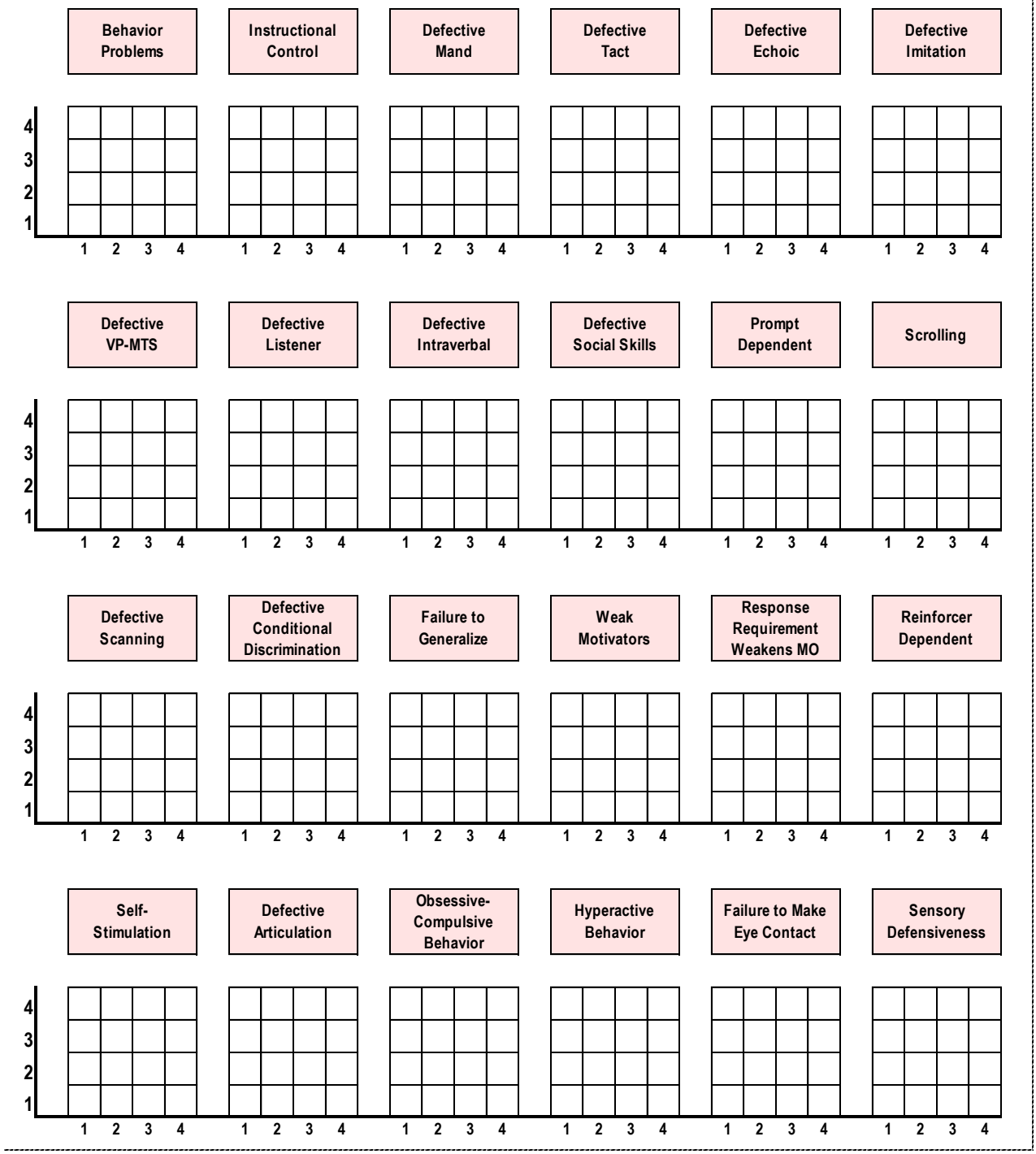
	Mand	Tact	Listener	VP/MTS	Play	Social	Imitation	Echoic	Vocal
5									
4									
3									
2									
1									

(Insert page break)

VB-MAPP Barriers to Learning

Child's name:	
Date of birth:	
Age at testing:	1 2 3 4

Key:	Score	Date	Color	Tester
1st test:				
2nd test:				
3rd test:				
4th test:				



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Vineland Adaptive Behavior Scales, 2nd Edition

REPORT DATE: XX/XX/XXXX **IEHP ID:** XXXXXXXXXXX

Date Administered: **XX/XX/XXXX**

Name of Interview: **First Name/Last Name, Credentials**

Name of Respondent: **First Name/Last Name, relationship**

Assessment Summary:

Write a brief narrative about the results and include the following in a paragraph:

- If there are significant differences between what is reported by the respondent to your observations, note that tactfully
- Note the Adaptive Behavior Composite score from last year and any significant changes with the results since then
- Refer the reader to reference last year's report for full Vineland scores

Domain	Standard Score*	95% Confidence Interval**	Age Equivalent***	Adaptive Level****
Communication				
Receptive			3 years, 5 months	
Expressive				
Daily Living Skills				
Personal				
Domestic				
Community				
Socialization				
Interpersonal Relationships				
Play and Leisure Time				
Coping Skills				
Motor Skills				
Gross Motor				
Fine Motor				
Adaptive Behavior Composite				

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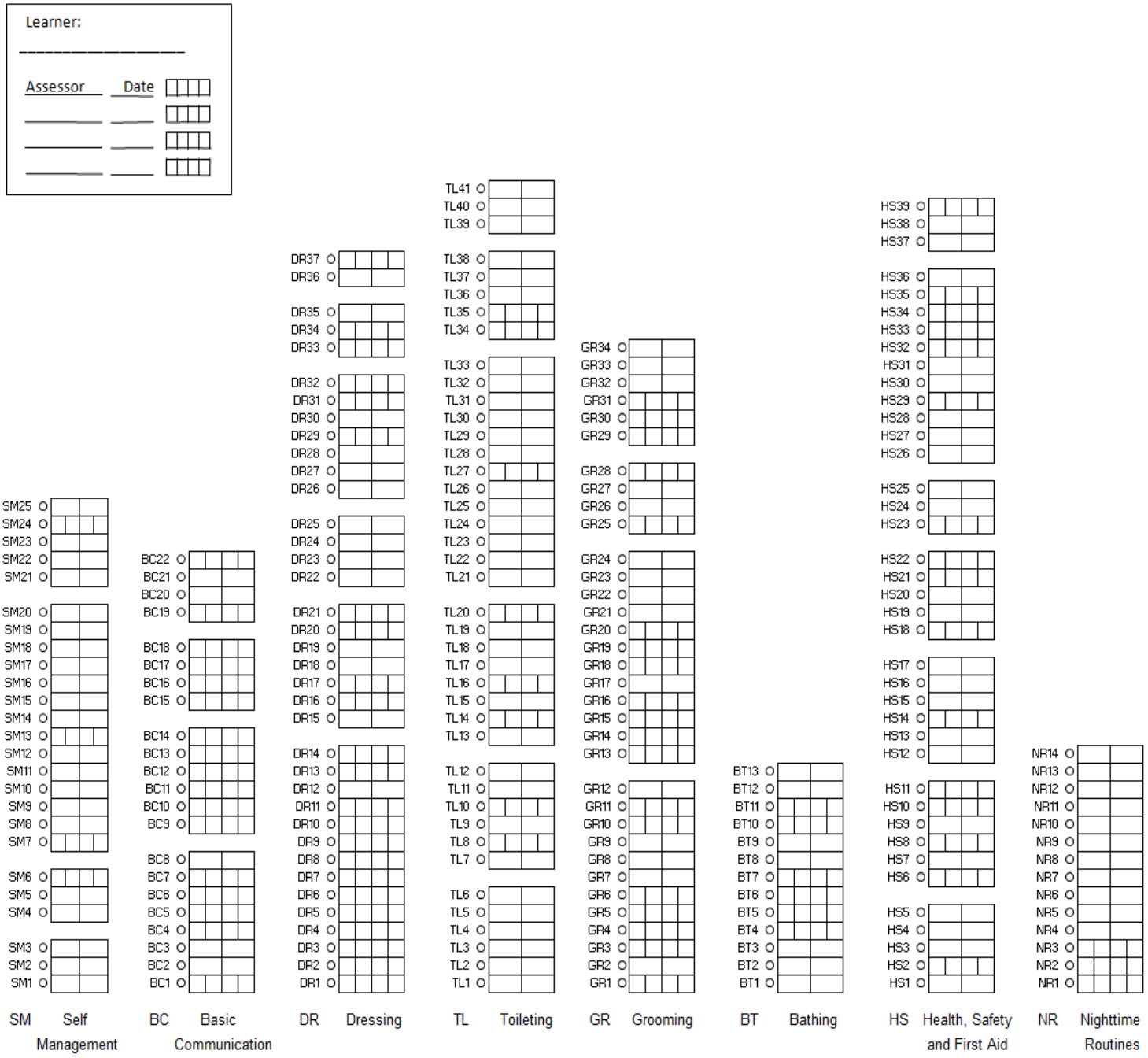

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Adaptive Behavior Assessment System, Third Edition (ABAS-3)

REPORT DATE: XX/XX/XXXX **IEHP ID:** XXXXXXXXXXXX

Date Administered: XX/XX/XXXX

Name of Interview: First Name/Last Name, Credentials

Name of Respondent: First Name/Last Name, relationship

Age: XX years, XX months

Age at Testing: XX years, XX months

Assessment Summary:
Write a brief narrative about the results and include the following in a paragraph:

Skill Area	Raw Score	Scaled Score	Description
Communication			
Community Use			
Functional Academics			
Home Living			
Health and Safety			
Leisure			
Self-Care			
Self-Direction			
Social			
Work			

(Insert page break)

VIII. Target Behaviors

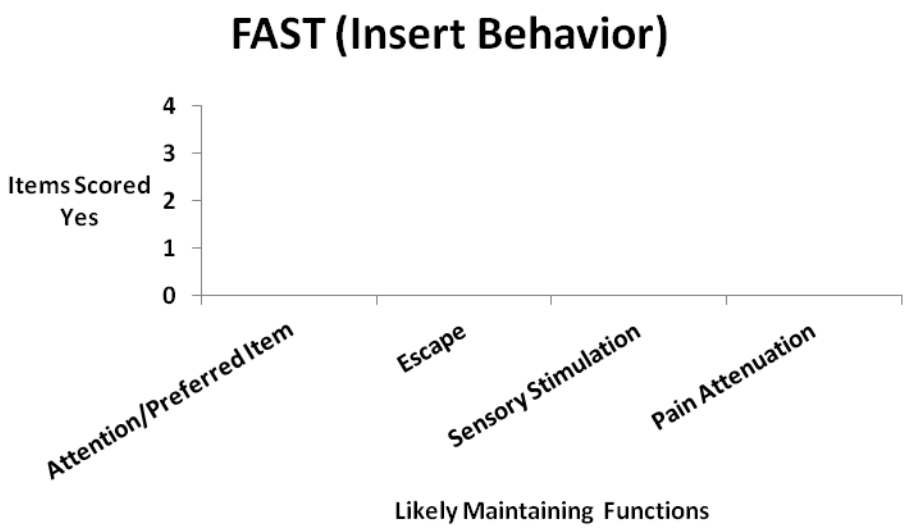
Behavior #1 (Insert Behavior Name)

Assessor will follow this behavior series for each target behavior Identified.

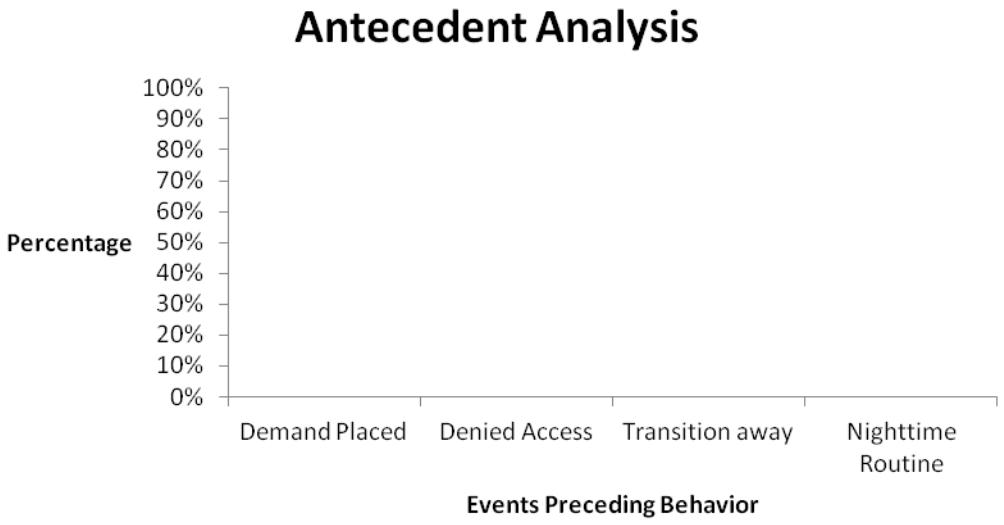
a. Descriptive Phase

- **Topography of Behavior:** Operational definition of the target behavior. The definition will be observable, measurable, and objective. (Based on this technological description all individuals will be able to easily recognize and record behavior). Definition should include criteria regarding what is and is not counted as the target behavior (e.g., duration, severity, instances vs. episodes, etc.).
- **Onset/Offset:** Statement regarding when the behavior begins and ends.
- **Course of Behavior:** Describe whether or not the behavior occurs across (persons, places, and times of the day). List any escalation patterns and/or cycles. Describe how the behavior typically subsides.
- **History and recent changes:** Write a brief statement regarding the history of the behavior and any recent changes to the behavior.
- **Source:** What social significance does the behavior serve (e.g., parental concern, observation)
- **Baseline Data:** Insert baseline data for target behavior.
  (Insert graph – align left)

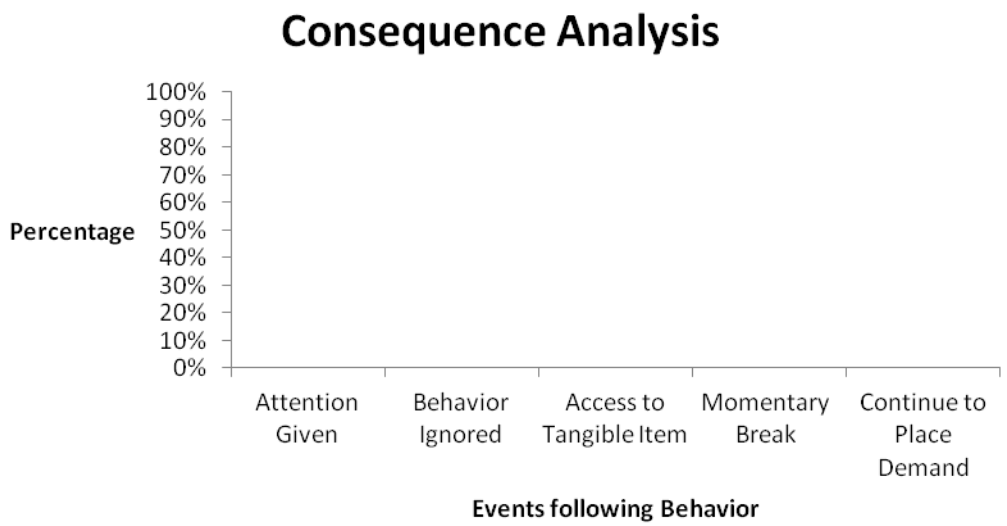
- ***Functional Analysis Screening Tool (e.g., FAST, MAS, QABF):*** Write a brief description of the tool used. Example: *The Functional assessment screening tool is a questionnaire presented to caregivers of an individual in order to identify a hypothesized function for a given target behavior. Questions asked to caregivers are presented in a random order and designed to assess whether the behavior occurs in the presence/ absence of a variety of environmental factors.*
  (Insert graph – align left)



- **Antecedent Analysis:** *Within this section the assessor will identify setting of events and triggering events for the target behavior. The assessor will summarize environmental events that preceded the target behavior.*
(Insert graph – align left)



- **Consequence Analysis:** *Within this section the assessor will identify environmental events that follow/followed the target behavior.*
(Insert graph – align left)



- **Analysis of Meaning/Hypotheses:** *Based on the information gathered from (Clinical Interview, Screening Tools, Direct Observation and Structured A-B-C Data collection, Antecedent and Consequence Analysis) the hypothesized function of Member's (insert behavior) is (insert function or multiple functions).*

b. Verification Phase

- **Functional Assessment: (*This section is optional*).** *Within this section describe the functional analysis procedures, testing conditions and the results. A graph is required for each testing condition.*

IX. Program Goals

1. Behavior:

1. **Program Name:** Title of program being targeted
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

2. **Program Name:** Title of program being targeted
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

2. Communication:

3. **Program Name:** Title of program being targeted
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

4. **Program Name:** Title of program being targeted
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

3. Self-Help:

5. **Program Name:** Title of program being targeted
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

6. **Program Name:** Title of program being targeted
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

4. Social Skills:

7. **Program Name:** Title of program being targeted
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

8. **Program Name:** Title of program being targeted
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

X. Behavior Intervention Plan

a. Ecological Strategies- *Within this section of the behavior intervention plan describe all ecological strategies used.* ***Strategies should be written technological.***

- ***(Insert Strategy)- Description of the strategy and instructions for implementation.***
- ***(Insert Strategy)- Description of the strategy and instructions for implementation.***

b. Antecedent Based Intervention Strategies- *Within this section of the behavior intervention plan describe all antecedent interventions used.* ***Strategies should be written technological. Examples include but not limited to:*** *Visual schedules, priming, clear expectations, first/then contingency training, structured choices, etc.*

- ***(Insert Strategy)- Description of the strategy and instructions for implementation.***
- ***(Insert Strategy)- Description of the strategy and instructions for implementation.***

c. Reactive/Consequence Based Intervention Strategies- *Within this section of the behavior intervention plan describe all consequence interventions used.* ***Strategies should be written technological. Examples include but not limited to: redirection, extinction, differential reinforcement, etc.***

- ***(Insert Strategy)- Description of the strategy and instructions for implementation.***

d. Safety Procedure- *Within this section please provide safety procedures used to keep the Member and other's safe during crisis situations, extinction bursts, and behavior escalation. This can include any special instructions from the QASP's adoptive Crisis Prevention Training Programs (e.g., Nonviolent Crisis Intervention, Safety-Care Behavioral Safety, Professional Crisis Management, or Professional Assault Crisis Training).*

XI. **Teaching Intervention Strategies-** *Within this section list all teaching procedures and methodologies used to ~~the~~ teach skill deficits and replacement behaviors. Include strategies on generalization, maintenance, thinning schedules of reinforcement, transition to natural mediators, and relapse prevention.*

a. (Insert Teaching Approach/Strategy/Procedure)- Provide a description of the research and evidence-based teaching approach. Additionally, provide any instructions for implementation.

XII. Family Involvement: *Within this section of the report Provider will outline parent involvement and participation within the therapy session. Provider will include a statement on the expected level of participation as outlined within the Behavioral Health Treatment IEHP Policy. Provider will outline the parent training and education approach for teaching the parent goals. Providers will include a plan on how the provider will address parental involvement within therapy sessions. Parent education goals will be listed below.* ***Parent Participation is not an education goal, it is an expectation. A Parent must have AT LEAST 2 Parent Education Goals.***

5. Parent Education:

1. **Parent Goal Domain:** Title of Domain being targeted
Instrumental Goal: Objective of the program (make sure this is measurable, objective, and specific) include data collection procedure and mastery criteria.
Baseline: Include a brief statement about the Member's Parent's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

2. **Parent Goal Domain:** Title of Domain being targeted
Instrumental Goal: Objective of the program (make sure this is measurable, objective, and specific) include data collection procedure and mastery criteria.
Baseline: Include a brief statement about the Member's Parent's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

XIII. Location of Service: *Include a description on where services will take place.* **Provider may not provide services in the school setting, day care, or other locations in which parent or caregiver is not present, unless prior authorization is given by the health plan.**

XIV. Coordination of Care: *Include a description on how the treatment team assigned to the Member's case will work* collaboratively with, their school, behavioral health provider and other health care professionals involved in the care of a Member (e.g., PCP, OT, SLP).

XV. Discharge Criteria: *Within this section include a description regarding the discharge criteria and transition of care. Transition of care should include Member aging out of BHT services at the age of 21. Authorizations for BHT will not extend past the Member's 21st birthday. For Members who are within sixty (60) days of their 21st birthday, the BHT Provider must initiate the transition process to an alternative funding source (e.g., Regional Center, County Services, or Department of Rehabilitation).*

XVI. Recommendations: *Within this section provide a summary of the clinical recommendations for the Member. This should include the rational for* ***MEDICALLY NECESSARY*** *behavioral health treatment. The rate of supervision provided by the QAS Professional and/or QAS Provider to the QAS Paraprofessionals will be based on a ratio of 2*

hours of supervision service per every 10 hours of direct service authorized, unless the case calls for increased supervision as agreed by QAS Provider and IEHP Health Plan. ***Providers requesting additional supervision beyond standard ratios and guidelines will need to include clinical justification on the need for enhanced supervision***

Report completed by:

SIGNATURE REQUIRED

Name
Title
Agency Name

Date:

Report reviewed and approved by: ***The Health plan requires a second review by BCBA***

SIGNATURE REQUIRED

Name
Title
Agency Name

Date:

Inland Empire Health Plan
Social Skills Assessment Report

Treatment whose sole purpose is vocational or recreationally based is not considered social skills intervention.

I. GENERAL INFORMATION:

First Name:		**Last Name:**	
Birth Date:		**IEHP Member ID#:**	
Present Address:			
Parent/Guardian:		**Phone:**	
Language:		**Referral Date:**	
Report Date:		**Assessor/Certification:**	

II. PRESENTING CONCERNS:

Write a brief description regarding the presenting concerns and why the Member is seeking services from your agency.

III. Social Skills Setting:

The social skills intervention setting for member: *Services are to be provided in a conventional setting.*

☐ Individual Home Setting	☐ Group Community/Clinic Setting

IV. SOCIAL SKILLS IDENTIFIED DEFICITS:

The social skills to be addressed are:

☐ Self-Awareness	☐ Decision Making	☐ Conversation Skills	☐ Turn Taking
☐ Self-Management	☐ Self-Control	☐ Sportsmanship	☐ Negotiation
☐ Social Awareness	☐ Emotions/Social Cues	☐ Bullying	☐ Problem Solving
☐ Relationship Skills	☐ Interpersonal Skills	☐ Conflict Resolution	☐ Cooperative Play
☐ Perspective Taking	☐ Theory of Mind	☐ Joint Attention	☐ Executive Functioning
☐ Restrictive Interests	☐ Social-Emotional Reciprocity		
☐ Other: _____			

V. BACKGROUND INFORMATION:

a. Living Situation-

Within this section describe where and with whom the Member lives (include any custody/visitation orders, childcare arrangements).

b. School Information-

Within this section list the Member's school information: Grade Level, School placement (e.g., General Education Class, Specialized Academic Support, Autism Program, Mild/Moderate, Moderate/Severe, or Non-Public School), School name, School attendance days and hours, frequency and duration of related services provided by the school district (e.g., Occupational Therapy, Speech Therapy, Physical Therapy, Adaptive Physical Education, Counseling, Nursing, Applied Behavior Analysis).

c. Health and Medical-

Within this section provide the Member's psychological and medical diagnoses (include when and who provided the diagnoses). Describe the Member's birth history, major illness, surgeries, hospitalizations, seizure history, allergies, hearing and vision screening results, vaccination, specialized diet, food consumption challenges or sleep difficulties. Include a list of medications and their relevance to behavior services.

d. Current Services and Activities-

Within this section list the weekly frequency and duration of all services funded by insurance (e.g., OT, ST, PT, Social Skills) and Inland Regional Center (e.g., Infant Stimulation, Respite, Adaptive Skills, Day Program). Additionally, include any weekly activities the Member participates in (e.g., Boy/Girl Scouts, Baseball, Basketball, Soccer, Dance/Gymnastics, Art therapy, etc.).

e. Intervention History-

Within this section list discuss the Member's intervention history. This includes services received during 0-3 (infant program), ABA services received through regional center or private insurance, social recreation/community integration, adaptive skills training, speech therapy, occupational therapy, and physical therapy. (List the weekly frequency and duration, the length of time the Member received the therapy and the provider/agency that provided the services).

VI. DESCRIPTION OF ASSESSMENT PROCEDURES:

Procedures:	Date and Location:	Person involved (indicate credentials):
☐ Records Reviewed:		
☐ Clinical Interview:		
☐ 1st Member Observation:		

Assessment Measures Administered:	Date(s) Administered:
☐ Vineland Adaptive Behavior Scales, 3rd Edition	
☐ SSIS Social-Emotional Learning Edition (SSIS SEL)	
☐ Social Responsiveness Scale	
☐ Social Communication Questionnaire	

a. *Records reviewed included:* *Within this section of the report, include any records reviewed (examples: Individual Program Plan (IPP), Psycho-Diagnostic Evaluation (PDE), Early Start Report, Functional Behavior Assessment, Intensive Intervention Progress Report, Individual Education Plan (IEP), etc.). Report title, report date and report author information are required for each document reviewed.*

Records reviewed include:
Example:
1. ***Psycho-Diagnostic Evaluation*** (Report Author, XX/XX/XXXX).

b. *Clinical Interview-* *Within this section the assessor will narrate the date, time, location, and persons involved in the clinical interview. The assessor will write a summary of parental concerns regarding the member's deficits for social skills intervention, this could include the recommendations for social skills following a Psycho-Diagnostic Evaluation, difficulties getting along with peers and/or delayed social skills.*

c. *First Member Observation-* *Within this section the assessor will narrate the date, time, location, and person's involved in the first observation of the Member. The assessor will briefly describe significant events (e.g., skill observations, direct observation of skill occurrence) pertaining to the Member's challenging Skills.*

VII. ASSESSMENT MEAURES:

Vineland Adaptive Behavior Scales, 3rd Edition

Date Administered: XX/XX/XXXX

Name of Interview: First Name/Last Name, Credentials

Name of Respondent: First Name/Last Name, relationship

Assessment Summary:

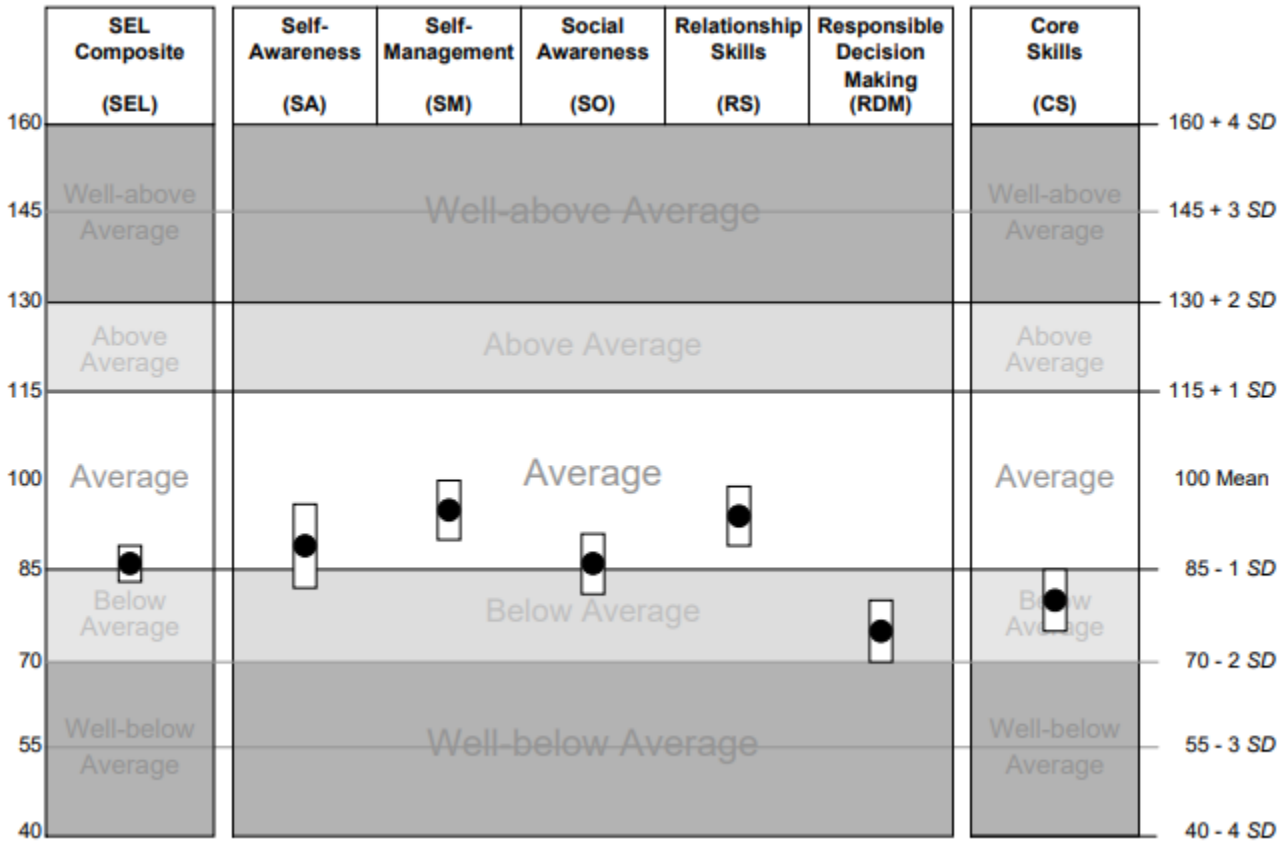
Write a brief narrative about the results and include the following in a paragraph:

- If there are significant differences between what is reported by the respondent to your observations, note that tactfully
- Note the Adaptive Behavior Composite score from last year and any significant changes with the results since the previous year
- Refer the reader to reference last year's report for full Vineland scores

Domain	Standard Score*	95% Confidence Interval**	Age Equivalent***	Adaptive Level****
Communication				
Receptive			3 years, 5 months	
Expressive				
Daily Living Skills				
Personal				
Domestic				
Community				
Socialization				
Interpersonal Relationships				
Play and Leisure Time				
Coping Skills				
Motor Skills				
Gross Motor				
Fine Motor				
Adaptive Behavior Composite				

(Insert page break)

Score Profile



Score Table

	SEL	SA	SM	SO	RS	RDM	CS
Standard Score							
Confidence Interval							
Percentile Rank							
Raw Score							
Response Pattern Index: Raw Score =							

(Insert page break)

Social Responsiveness Scale, Second Edition (SRS-2)

Member Information

Member Name	Gender	Age at testing

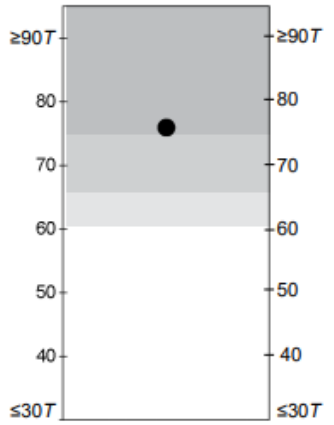
Rater's name	Relationship to rated individual

Assessment Information

Examiner's name	Administration date

Score Profile

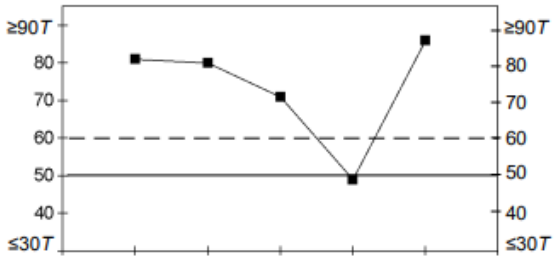
SRS-2 Total Score Results



Total raw score: 90
***T*-score: 76**

≥76T: Severe *66T-75T: Moderate*
60T-65T: Mild *≤59T: Normal*

Treatment Subscale Results



T	Awr	Cog	Com	Mot	RRB
Raw score	15	21	27	5	22
***T*-score**	81	80	71	49	86

Awr = Social Awareness Com = Social Communication
Cog = Social Cognitive Mot = Social Motivation
RRB = Restricted Interests and Repetitive Behavior

***DSM-5* Compatible Subscales**	Raw score	*T*-score
Social Communication and Interaction:	68	72
Restricted Interests and Repetitive Behavior:	22	86

Total Score Discussion

Within this section insert the narrative information about the total score.

(Insert page break)

Social Responsiveness Scale, Second Edition (SRS-2)

Name of subject	Gender	Clinician name	
SCQ Sample	Male	Sample Clinician	
Name of respondent		Year	Month
Sample Parent	Date of interview	2017	9
Relation to subject			
Mother	Date of birth	2009	1
School/clinic			
Sample Elementary School	Chronological age	8	8

SCQ TOTAL SCORE: 25

Total scores of 15 or greater on the Lifetime form indicate a possible autism spectrum disorder (ASD) and, therefore, the need for a comprehensive evaluation.

SUMMARY OF TEST DATA ENTRY

1.	Yes	**11.**	Y (1)	**21.**	N (1)	**31.**	N (1)
2.	N (1)	**12.**	N (0)	**22.**	N (1)	**32.**	Y (0)
3.	Y (1)	**13.**	N (0)	**23.**	N (1)	**33.**	N (1)
4.	Y (1)	**14.**	Y (1)	**24.**	N (1)	**34.**	Y (0)
5.	N (0)	**15.**	Y (1)	**25.**	N (1)	**35.**	N (1)
6.	Y (1)	**16.**	Y (1)	**26.**	Y (0)	**36.**	Y (0)
7.	Y (1)	**17.**	N (0)	**27.**	Y (0)	**37.**	Y (0)
8.	Y (1)	**18.**	N (0)	**28.**	N (1)	**38.**	Y (0)
9.	N (1)	**19.**	Y (0)	**29.**	N (1)	**39.**	N (1)
10.	Y (1)	**20.**	N (1)	**30.**	Y (0)	**40.**	N (1)

Response Key:
Y = Yes
N = No
- = Missing (not answered)
n/a = Not Applicable

Missing required responses: 0

(Insert page break)

VIII. SOCIAL SKILLS GOALS: *Goals should be agreed upon by the member and/or guardian (as appropriate), and incorporate the member's perspective on current problems, as well as the member's specific values and preferences (e.g., social significance). The goal should also be developmentally appropriate and based on clinical observation and assessment measure.*

1. Communication:

1. **Program Name:** Title of program being targeted
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

2. **Program Name:** Title of program being targeted
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

2. Social Skills:

3. **Program Name:** Title of program being targeted
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

4. **Program Name:** Title of program being targeted
Instrumental Goal: (By Date) Objective of the program (make sure this is measurable, objective, and specific)
Data Collection: How data will be collected (e.g., first trial data, rate per hour, percentage of opportunities, partial interval recording)
Mastery Criteria: How you will measure mastery (e.g., 3 consecutive sessions of correct responding)
Generalization Criteria: How you will measure if the skill is generalized (e.g., Across 3 people, 3 settings, and 3 exemplars)
Baseline: Include a brief statement about the Member's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

IX. **Social Skills Curriculum-** *Within this section the provider will list the social skills curriculum that is being used to facilitate the social skills group and/or individualized social skills intervention with the member. According to the National Standard Project Phase 2, the social skills intervention package needs to be evidence based.*

X. **Teaching Intervention Strategies-** *Within this section list all teaching procedures and methodologies used to ~~the~~ teach skill deficits and replacement behaviors. Include strategies on generalization, maintenance, thinning schedules of reinforcement, transition to natural mediators, and relapse prevention.*

a. (Insert Teaching Approach/Strategy/Procedure)- Provide a description of the research and evidence-based teaching approach. Additionally, provide any instructions for implementation.

b. (Insert Teaching Approach/Strategy/Procedure)-Including cognitive behavioral intervention, modeling, naturalistic intervention, pivotal response training, self-management, social narratives, technology aided instruction, and video-modeling.

3. Parent Education:

1. **Parent Goal Domain:** Title of Domain being targeted
Instrumental Goal: Objective of the program (make sure this is measurable, objective, and specific) include data collection procedure and mastery criteria.
Baseline: Include a brief statement about the Member's Parent's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

2. **Parent Goal Domain:** Title of Domain being targeted
Instrumental Goal: Objective of the program (make sure this is measurable, objective, and specific) include data collection procedure and mastery criteria.
Baseline: Include a brief statement about the Member's Parent's current skill level including a baseline measurement that EXACTLY matches the mastery criteria of the goal.

XI. Location of Service: *Include a description on where services will take place.* **Provider may not provide services in the school setting, day care, or other locations in which parent or caregiver is not present, unless prior authorization is given by the health plan.**

XII. Coordination of Care: *Include a description on how the treatment team assigned to the Member's case will work* collaboratively with, their school and other health care professionals involved in the care of a Member (e.g., PCP, OT, SLP).

XIII. Discharge Criteria: *Within this section include a description regarding the discharge criteria and transition of care. Transition of care should include Member aging out of BHT services at the age of 21. Authorizations for BHT will not extend past the Member's 21st birthday. For Members who are within sixty (60) days of their 21st birthday, the BHT Provider must initiate the transition process to an alternative funding source (e.g., Regional Center, County Services, or Department of Rehabilitation).*

XIV. Recommendations: *Within this section provide a summary of the clinical recommendations for the Member. This should include the rational for* ***MEDICALLY NECESSARY*** *behavioral health treatment.*

Clinical Recommendations		
CPT	**Description**	**Units Requested**
S5111	**Home Care Training, Family; per session (By BCBA, BCaBA, MA staff)**	
H2014	**Skills Training and Development, per 15 minutes (By BCBA, BCaBA, MA staff)**	

Report completed by:

SIGNATURE REQUIRED

Name
Title
Agency Name

Date:

Report reviewed and approved by:

SIGNATURE REQUIRED

Name
Title
Agency Name

Date:

Attachment 12 - CCS Client Service Auth Request - Established Case

ESTABLISHED CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request	2. Provider name	3. Provider number

4. Address (number, street) | City | State | ZIP code

5. Contact person	6. Contact telephone number ( )	7. Contact fax number ( )

Client Information

8. Client name—last | First | Middle

9. Gender ☐ Male ☐ Female	10. Date of birth (mm/dd/yyyy)	11. CCS/GHPP case number

12. Client index number (CIN)	13. Client's Medi-Cal number

Diagnosis

14. Diagnosis (DX)/ICD-10:_____ DX/ICD-10:_____ DX/ICD-10:_____

15. Service Authorization Request for *(Check one)*

☐ a. CCS/GHPP New SAR

☐ b. Authorization extension (If checked, enter authorization number:_____)

Requested Services

16.* CPT-4/ HCPCS Code/NDC	17. Specific Description of Service/Procedure	18. From (mm/dd/yy)	To (mm/dd/yy)	19. Frequency/ Duration	20. Units	21. Quantity (Pharmacy Only)

* A specific procedure code/NDC is required in column 16 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.

22. Other documentation attached ☐ Yes	23. Enter facility name (where requested services will be performed, if other than office.)

Inpatient Hospital Services

24. Begin date	25. End date	26. Number of days	27. Extension begin date	28. Extension end date	29. Number of extension days

Additional Services Requested from Other Health Care Providers

30. Provider's name	Provider number	Telephone number ( )	Contact person

Address (number, street) | City | State | ZIP code

Description of services	Procedure code	Units	Quantity

Additional information

31. Provider's name	Provider number	Telephone number ( )	Contact person

Address (number, street) | City | State | ZIP code

Description of services	Procedure code	Units	Quantity

Additional information

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not be processed.

32. Signature of physician/provider or authorized designee	33. Date

INSTRUCTIONS

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Provider number: Enter billing number (no group numbers).
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.

Client Information

8. Client name: Enter the client's name—last, first, and middle.
9. Gender: Check the appropriate box.
10. Date of birth: Enter the client's date of birth.
11. CCS/GHPP case number: Enter the client's California Children's Services (CCS)/Genetically Handicapped Persons Program (GHPP) number. If not known, leave blank.
12. Client index number (CIN): Enter the client's CIN number. If not known, leave blank.
13. Client's Medi-Cal number: Enter the client's Medi-Cal number. If number is not known, leave blank.

Diagnosis

14. Diagnosis and/or ICD-10: Enter the diagnosis or ICD-10 code, if known, relating to the requested services.

Requested Services

15. a. CCS/GHPP New SAR: Check if requesting a new authorization for an established CCS/GHPP client.
    b. Authorization extension: Check if requesting an extension of an authorized request. Please enter the authorization number on the line.
16. CPT-4/HCPCS code/NDC: Enter the requested CPT-4, HCPCS code, or NDC code. This is only required if services requested are other than ongoing physician authorizations or special care center authorizations. Also not required for inpatient hospital stay requests.
17. Specific description of procedure/service: Enter the specific description of the procedure/service being requested.
18. From and to dates: Enter the date you would like the services to begin. Enter the date you would like the services to end. These dates are not necessarily the dates that will be authorized.
19. Frequency/duration: Enter the frequency or duration of the procedures/services being requested.
20. Units: For NDC, enter the total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
21. Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
22. Other documentation attached: Check this box if attaching additional documentation.
23. Enter facility name: Complete this field with the name of the facility where you would like to perform the surgery you are requesting.

Inpatient Hospital Services

24. Begin date: Enter the date the requested inpatient stay will begin.
25. End date: Enter the date the requested inpatient stay will end.
26. Number of days: Enter the number of days for the requested inpatient stay.
27. Extension begin date: Enter the date the requested extension of authorized inpatient stay will begin.
28. Extension end date: Enter the date the requested extended stay will end.
29. Number of extension days: Enter number of days for the requested extension inpatient stay.

Additional Services Requested from Other Health Care Providers

30. and 31. Provider's name: Enter name of the provider you are referring services to.
    Provider number: Enter the provider's provider number.
    Telephone: Enter provider's telephone number.
    Contact person: Enter the name of the person who can be contacted regarding the request.
    Address: Enter address of the provider.
    Description of services: Enter description of referred services.
    Procedure code: Enter the procedure code for requested service other than ongoing physician services.
    Units: For NDC, enter the total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
    Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
    Additional information: Include any written instructions/details here.

Signature

32. Signature of physician or provider: Form must be signed by the physician, pharmacist, or authorized representative.
33. Date: Enter the date the request is signed.

Attachment 12 - CCS-GHPP Client Service Auth Request - New Case

NEW REFERRAL CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request	2. Provider name	3. Provider number
4. Address (number, street)	City	State ZIP code
5. Contact person	6. Contact telephone number ( )	7. Contact fax number ( )

Client Information

8. Client name—last	first	middle
9. Alias (AKA)	10. Gender ☐ Male ☐ Female	11. Date of birth (mm/dd/yy)
12. CCS/GHPP case number	13. Medical record number (hospital or office)	14. Home phone number ( )
15. Cell phone number ( )	16. Work phone number ( )	17. Email address
18. Residence address (number, street) *(DO NOT USE P.O. BOX)*	City	State ZIP code
19. Mailing address (if different) (number, street, P.O. box number)	City	State ZIP code
20. County of residence	21. Language spoken	22. Name of parent/legal guardian
23. Mother's first name	24. Primary care physician (if known)	25. Primary care physician telephone number ( )

Insurance Information

26.a. Enrolled in Medi-Cal? ☐ Yes ☐ No	26.b. If yes, client index number (CIN)	26.c. Client's Medi-Cal number
27. Enrolled in commercial insurance plan ☐ Yes ☐ No	If yes, type of commercial insurance plan ☐ PPO ☐ HMO ☐ Other	Name of plan

Diagnosis

28.
Diagnosis (DX)/ICD-10:_____ DX/ICD-10:_____ DX/ICD-10: _____

Requested Services

29.* CPT-4/ HCPCS Code/NDC	30. Specific Description of Service/Procedure	31. From (mm/dd/yy)	To (mm/dd/yy)	32. Frequency/ Duration	33. Units	34. Quantity (Pharmacy Only)

* A specific procedure code/NDC is required in column 27 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.

35. Other documentation attached ☐ Yes	36. Enter facility name (where requested services will be performed, if other than office).

Inpatient Hospital Services

37. Begin date	38. End date	39. Number of days

Additional Services Requested from Other Health Care Provider

40. **Provider's name**	Provider number	Telephone number ( )	Contact person
Address (number, street)	City	State	ZIP code

Description of services	Procedure code	Units	Quantity
Additional information			

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not be processed.

41. Signature of physician/provider or authorized designee	42. Date

Instructions

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Provider number: Enter National Provider Identification (NPI) number (no group numbers).
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.

Client Information

8. Client name: Enter the client's name—last, first, and middle.
9. Alias (AKA): Enter the patient's alias, if known.
10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
12. CCS/GHPP case number: Enter the client's California Children's Services (CCS)/Genetically Handicapped Persons Program (GHPP) number. If not known, leave blank.
13. Medical record number: Enter the client's hospital or office medical record number.
14. Home phone number: Enter the home phone number where the client or client's legal guardian can be reached.
15. Cell phone number: Enter the cellular phone number where the client or client's legal guardian can be reached.
16. Work phone number: Enter the work phone number where the client or client's legal guardian can be reached.
17. Email address: Enter the email address of the client or client's legal guardian.
18. Residence address: Enter the address of the client. Do not use a P.O. Box number.
19. Mailing address: Enter the mailing address if it is different than number 18.
20. County of residence: Enter residential county of the client.
21. Language spoken: Enter the client's language spoken.
22. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
23. Mother's first name: Enter the client's mother's first name.
24. Primary care physician: Enter the client's primary care physician's name. If it is not known, enter NK (not known).
25. Primary care physician telephone number: Enter the client's primary care physician phone number.

Insurance Information

26a. Enrolled in Medi-Cal? Mark the appropriate box. If the answer is yes, enter the client's index number in box 26.b. and the client's Medi-Cal number in box 26.c.

27. Enrolled in a commercial insurance plan? Mark the appropriate box, if the answer is yes, mark the type of insurance plan and enter the name of the commercial insurance plan on the line provided.

Diagnosis

28. Diagnosis and/or ICD-10: Enter the diagnosis or ICD-10 code, if known, relating to the requested services.

Requested Services

29. CPT-4/HCPCS code/NDC: Enter the CPT-4, HCPCS code or NDC code being requested. This is only required if services requested are other than ongoing physician authorizations or special care center authorizations. Also not required for inpatient hospital stay requests.
30. Specific description of procedure/service: Enter the specific description of the procedure/service being requested.
31. From and to dates: Enter the date you would like the services to begin. Enter the date you would like the services to end. These dates are not necessarily the dates that will be authorized.
32. Frequency/duration: Enter the frequency or duration of the procedures/service being requested.
33. Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
34. Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
35. Other documentation attached: Check this box if attaching additional documentation.
36. Enter facility name: Complete this field with the name of the facility where you would like to perform the surgery you are requesting.

Inpatient Hospital Services

37. Begin date: Enter the date the requested inpatient stay shall begin.
38. End date: Enter the end date for the inpatient stay requested.
39. Number of days: Enter the number of days for the requested inpatient stay.

Additional Services Requested from Other Health Care Providers

40. Provider's name: Enter name of the provider you are referring services to.
Provider number: Enter the provider's National Provider Identification (NPI) number. Telephone: Enter provider's telephone number.
Contact person: Enter the name of the person who can be contacted regarding the request. Address: Enter address of the provider.
Description of services: Enter description of referred services.
Procedure code: Enter the procedure code for requested service other than ongoing physician services.
Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
Additional information: Include any written instructions/details here.

Signature

41. Signature of physician or provider: Form must be signed by the physician, pharmacist, or authorized representative.
42. Date: Enter the date the request is signed.

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ENROLLMENT FORM

GENERAL INFORMATION

Last Name	First Name			Middle Initial
Preferred Nickname *(if applicable)*	Mother's Maiden Name			Your Birthdate
Street Address	City	County	State	ZIP Code

How long at this address?		**Social Security#**	
Living Situation *(Circle One)*	Addictions Treatment Homeless Friends/Family Own Home Rental Transitional Housing	Describe your Living situation	Stable Temporary Unstable
Provide your previous address			
Have You Been a Client of D.A.P. Before?	Y N		

COMMUNICATON PREFERENCES

Your Telephone #		Type of Telephone	Home Mobile Work
May we contact you by U.S. Mail?	Y N	If yes, please provide your mailing address below	
Mailing Address or Same as above	City	State	ZIP Code
Email address to sign up for D.A.P.'s Patient Portal			

DEMOGAPHIC INFORMATION AND HEALTHCARE INFORMATION

Emergency Contact		**Relationship**		**Phone**	
Are you a U.S. Veteran?	Y N	Sex at Birth	M F	Gender identity	M F M/F F/M
Sexual Orientation	Gay/Lesbian Straight(not gay/lesbian) Bisexual Something else Choose not to disclose				
Other gender identity Preferred pronoun	HE/HIM SHE/HER THEY/THEM ZE/ZIM DECLINE TO ANSWER				
Marital Status *(Circle one)*	Co-Habitation Divorced Domestic Partner Married Single Widowed				
Race *(Circle all that apply)*	African-American American Indian/Alaskan Native Asian Caucasian Native Hawaiian/Pacific Islander				
Are you Latino?	Y N	National Origin *(Circle one)*	C. American Chinese Cuban Filipino Korean Malaysian Mexican Puerto Rican S. American Other		
Primary Language Spoken		Do you need an interpreter?	Y N		
Are You Hearing Impaired	Y N	Other Special Needs	Y N	If Yes, Other	
For FQHC purposes we ask:	# of family in your household		Monthly income	$	
Primary Care Physician		Contact Number			
Primary Insurance		ID#			
Secondary Insurance		ID#			
How did you hear about us?					
I certify that I am an individual living with HIV/AIDS	**YES NO**	**If NO HERE. IF YES CONTINUE ON BACK.**			

Your Signature **Today's Date**

Form Active: Nov 11, 2014 Revised: Oct 04, 2016

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ENROLLMENT FORM

HIV HEALTH HISTORY *(if applicable)*

Were you diagnosed with HIV with the last 12 months?	Y N	Date Tested HIV+	
Did you receive Post-Test counseling?	Y N	City, State tested HIV+	
What was the source of your HIV Test? *(Circle one)*	Medical Facility / Clinic HIV Test Event Hospital Self-test Other		
Have had HIV lab work completed by medical provider?	Y N	If yes, most recent date?	
Have you received HIV care in Riverside/San Bernardino Co. before?	Y N		
If YES, where?			
Have you received Ryan White-funded services before?	Y N	If yes, where?	

HIV EXPOSURE

Prior to HIV + Diagnosis, which of these factors were or are currently present? *(Please Circle all that apply)*

Sex with Male Sex with Female Injection of non-Rx drugs Work in health care / lab
Clotting Factor for Hemophilia Coagulation Disorder
Transfusion, Transplant, Artificial Insemination Prenatal Transmission Sexual Abuse

Heterosexual Contact Only – How were you exposed to HIV? *(Please Circle all that apply)*

Bisexual Male Person with Documented HIV/AIDS Intravenous/injection Drug User

Your Signature **Today's Date**

Form Active: Nov 11, 2014 Revised: Oct 04, 2016

Medical Services ***Only***

CHECKLIST OF REQUIRED INITIAL DOCUMENTS

REQUIRED ELIGIBILITY DOUCMENTATION	✓	ACCEPTED FORMS OF DOCUMENTS
GOVERNMENT ISSUED IDENTIFICATION *(please provide at least one)*		Current Photo ID
		Current Driver's License
		Current Passport
PROOF OF INCOME *(please provide at least one)*		3 Current Paystubs
		3 Months Direct Deposit Bank Statements
		SSA, SSI, or SSDI Annual Award Letter
		Medi-Cal Acceptance Letter
		Letter from other Government Assistance
		Signed Affidavit from Person of Support
PROOF OF INSURANCE		Insurance Card(s) (Medical and/or Dental)

Social Services & Medical Services

CHECKLIST OF REQUIRED INITIAL DOCUMENTS

REQUIRED ELIGIBILITY DOUCMENTATION	✓	ACCEPTED FORMS OF DOCUMENTS
GOVERNMENT ISSUED IDENTIFICATION *(please provide at least one)*		Current Photo ID
		Current Driver's License
		Current Passport
PROOF OF RESIDENCY – Proof of Riverside/San Bernardino Co. Residency for a minimum of 30 days *(please provide two)*		Current Utility Bill (within 30 days)
		Current Rental / Lease Agreement
		Voter Registration Card / DMV Card
		Signed Affidavit of Residency from Co-habitant
PROOF OF HIV DIAGNOSIS *(please provide at least one)*		Letter of HIV Diagnosis Signed by MD, PA, NP
		Confirmatory HIV+ Lab with Individual's Name
PROOF OF INCOME *(please provide at least one)*		3 Current Paystubs
		3 Months Direct Deposit Bank Statements
		SSA, SSI, or SSDI Annual Award Letter
		Medi-Cal Acceptance Letter
		Letter from other Government Assistance
		Signed Affidavit from Person of Support
PROOF OF INSURANCE		Insurance Card(s) (Medical and/or Dental)

State of California
Health and Human Services Agency

Department of Health Care Services
Genetically Handicapped Persons Program (GHPP)

GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP)
APPLICATION TO DETERMINE ELIGIBILITY

Refer to the Instructions on Page 4, 5 and 6 When Filling in this Application

Please provide all the information requested and return this form to the GHPP. PLEASE TYPE OR PRINT. DO NOT ABBREVIATE.

If you have any questions about completing this form, email the GHPP at GHPPEligibility@dhcs.ca.gov or call 1 (916) 552-9105 or toll free at 1 (800) 639-0597.

Section A: Personal Information

1. Name (Last) (First) (MI)		2. Other Name(s) Used		3. Social Security Number (Optional)
4. Address		City	County	Zip Code
4(a). Mailing Address (if different)		City	County	Zip Code
5. Day Telephone	6. Email Address	7. Mother's First and Maiden Name		8. Language
9. Date of Birth	10. Place of Birth: County, State, Country			11. Gender
12. What is your GHPP Eligible Condition?				
13. Race/Ethnicity				

14. Name of the Physician who Treats your GHPP Eligible Condition. Include NPI Number if known.

_____

14(a). Treating Physician's Address

_____

14(b) Physician's Contact Phone Number

_____ _____

15. Name of your Special Care Center Facility

_____

16. Power of Attorney / Conservator Information (If Applicable)

YOU MUST ATTACH SUPPORTING DOCUMENTATION

Name: _____

Title: _____

Address: _____

Telephone Number: _____

Section B: Health Insurance Information

17. Do you have Medi-Cal? Yes ☐ No ☐
a. If Yes, what is your Beneficiary I.D. Card (BIC) number?

18. Do you have Medicare? Yes ☐ No ☐ If yes, what is your medcare number?

18b. Please check all Medicare Programs you are enrolled: Part A ☐ Part B ☐ Part C ☐ Part D ☐

19.Do you have Other Health Insurance? Yes ☐ No ☐

a. If Yes: Through your Employer ☐ Through Family Member ☐ Through Retirement Benefits ☐

Insurance Company:

b. Type of Plan: Preferred Provider ☐ Health Maintenance Organization (HMO) ☐ (PPO)
Other (Specify):

c. Policy Number Coverage Start Date:

d. Who pays for the policy? Employer ☐ Self ☐ Employer and Self ☐

Other (Specify)

When Cost-Effective, the Health Insurance Premium Reimbursement (HIPR) Program may Reimburse for the cost of your Third-Party Health Coverage.
Are you Currently Participating in the HIPR Program? Yes ☐ No ☐

If yes, would you like the HIPR program to Continue Reimbursing you? If no, would you like Reimbursement for you Third-Party Health Coverage Premiums? Yes ☐ No ☐ Yes ☐ No ☐

f. Has any of your Insurance Information Changed Since the Last Filing? Yes ☐ No ☐

If yes, explain why:

Please Attach a copy of the Insurance Card. To Continue your Participation in the HIPR, Submit your GHPP Renewal Application Annually

g. If your employer provides health insurance and you choose not to participate in your employer's plan, state why below:

☐ The Premium is too Expensive
☐ I lost my job, am eligible to continue my coverage under COBRA, and can not afford to pay the insurance premium.
☐ I have met the lifetime coverage limit of my employer's health insurance coverage.
☐ The physician providing care for my condition is not part of the plan's provider network.
☐ Other (please specify)

Section B: Health Insurance Information

h. During the last six months from the date of this application, has either your employer or yourself terminated your employer's sponsored health insurance? Yes ☐ No ☐

If yes, what date was it terminated?

Please state why below:

- ☐ Change in employment status, including loss of employment.
- ☐ Your employer discontinued health benefits to all employees and/or dependents.
- ☐ A change of your address to a ZIP Code that is not covered by your employer's health insurance.
- ☐ Death of, or legal separation/divorce of, the individual through whom the health insurance was provided.
- ☐ You have met the lifetime coverage limit of the employer's health insurance.
- ☐ Coverage was under a COBRA policy and the COBRA coverage period has ended.
- ☐ Other (please specify)

20. Do You Have:

a. Dental Insurance Yes ☐ No ☐ If yes, name of plan:
b. Vision Insurance Yes ☐ No ☐ If yes, name of plan:

Section C: Certification

(Initial and Sign Below. Your Signature Authorizes GHPP to Proceed with Your Application.)

Read and Initial Each Statement Below:

I am applying to the GHPP in order to determine my eligibility for services/benefits. I understand that the completion of this application does not guarantee my acceptance into the GHPP.

I give my permission for the GHPP to verify my residence, health information, income and/or other circumstances which may be required to determine my GHPP eligibility and enrollment fee amount (if any).

I give permission for the GHPP to leave messages concerning my GHPP participation on my designated telephone answering machine/service.

I certify that I have read this information, or had it read to me, and that I understand it.

I certify that the information I have given on this form is true and correct to the best of my knowledge

Signature of GHPP Applicant or Parent/Legal Guardian of Minor/Child:	Relationship to Minor Child:	Date:
_____	_____	_____

If Signing with an "X", Signature of Witness:	Relationship of Witness to GHPP Applicant:	Witness Phone Number:	Date:
_____	_____		_____

California law requires that families applying for services be given information on how GHPP protects their privacy.[1] To protect your privacy:

- GHPP must keep this information confidential.[2]
- GHPP may share information on the form with authorized staff from other health and welfare

You have the right to see your application and GHPP records concerning you. If you wish to see these records contact the GHPP via email to GHPPEligibility@dhcs.ca.gov, or call 1 (916) 552-9105 or toll free at 1 (800) 639-0597. By law, the information you give GHPP is kept by the program.[3]

1) Civil Code, Section 1798.17
2) In accordance with Section 41670, Title 22, California Code of Regulations and the California Public Records Act (Government Code, Sections 6250-6255)
3) Section 123800 et. seq. of the California Health and Safety Code

Application to Determine GHPP Program Eligiblity

Sexual orientation and gender identity questions for the implementation of Assembly Bill 959, Lesbian, Gay, Bisexual, and Transgender (LGBT) Disparities Reduction Act.

Assembly Bill 959 (an act to add Section 8310.8 to the Government Code, relating to data collection, Chapter 565, 2015), Lesbian, Gay, Bisexual, and Transgender (LGBT) Disparities Reduction Act requires the Department of Health Care Services to collect voluntary information about applicants' sexual orientation and gender identity. Please fill in below to tell us more about the applicant's gender, gender identity, gender expression or sexual orientation

What was your sex assigned at birth? (required)

- [ ] Female
- [ ] Male
- [ ] Transgender

What is your gender identity? (optional)
(*check the box that best describes your current gender identity*)

- [ ] Female
- [ ] Male
- [ ] Transgender: Male to female
- [ ] Transgender: Female to male
- [ ] Non-Binary (neither male nor female)
- [ ] Another gender identity

What gender is listed on your original birth certificate? (optional)

- [ ] Female
- [ ] Male

Do you think of yourself as? (optional)

- [ ] Straight or heterosexual
- [ ] Gay or lesbian
- [ ] Bisexual
- [ ] Queer
- [ ] Another Sexual orientation
- [ ] Unknown

INSTRUCTIONS FOR COMPLETING
THE GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP) APPLICATION
TO DETERMINE ELIGIBILTY

Please print clearly so your application can be processed as quickly as possible.

Fill out each section completely. If you do not provide all the information requested, the GHPP will be unable to proceed with your application. If you need help in filling out this form, please contact the GHPP at 1 (916) 327-0470 or toll free at 1 (800) 639-0597. Once the application is completed, email it to the GHPP inbox GHPPEligibility@dhcs.ca.gov, or mail the application to Genetically Handicapped Persons Program MS 4502, P.O. Box 997413, Sacramento, CA 95899-7413. **PLEASE REMEMBER TO SIGN AND DATE THE FORM.**

Section A: Personal Information: This includes identifying information and other information necessary to process this form.

1. **Name:** Write your last name, first name, and middle initial. **Attach proof of identity, such as a copy of your California driver's license or California identification card to the application.**
2. **Other name(s) used:** If you are legally known by any other name, write in the name(s).
3. **Social Security Number (OPTIONAL):** Write your nine-digit Social Security Number.
4. **Address:** Write your residence street number, street name, apartment number, city, county, and zip **code. Do not use a P.O. Box in this space. Attach a copy of one of the following to show proof of residency in California. If you do not have one of the following items, please call the GHPP to discuss additional acceptable items.**

• Current California utility bill • Rent or mortgage receipt • Document showing employment in California	• Evidence of registering to vote in California • Evidence of enrollment in a California school • Evidence of receiving California public assistance

4a. Mailing address: Write your mailing address, a P.O. Box is acceptable.

5. Day telephone number: Write the telephone number where you can be reached during the day including area code.

6. Email Address: Write the email address where the applicant can be reached.

7. Mother's first and last (maiden) name: Write your mother's first name and last (maiden) name.

8. Primary language: Write the name of the language in which you are most comfortable communicating.

9. Date of birth: Write the month, day, and year of your birth.

10. Place of birth: Write the county and state in which you were born. Write the country if you were born outside of the United States.

11. Gender: Fill in the applicant's gender (male or female) or see page 4 to provide more information about the applicant's gender, gender identity, gender expression or sexual orientation.

INSTRUCTIONS FOR COMPLETING THE GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP) APPLICATION TO DETERMINE ELIGIBILTY

12. What is your GHPP eligible condition? Write the condition which qualifies you for the **GHPP. The following is a list of GHPP-eligible conditions:**

• Cystic Fibrosis • Friedreich's Ataxia • Hemophilla Factor Deficiency (please specify factor type) • Huntington's Disease • Joseph's Disease • Sickle Cell Disease • Thalassemia Major • Thrombasthenia	• Thrombocytopathia • Von Hippel-Lindau • Von Willebrand's Disease • Metabolic Disease (e.g., PKU, Tyrosinemia, branch chain amino acid, Maple Syrup Urine Disease, urea cycle disorders, Wilson's Disease) • Other metabolic disease (please specify)

13. Race/ethnicity: Write the category from the following list which best describes your primary **race/ethnicity.**

• Alaskan Native • Amerasian • American Indian • Asian • Asian Indian • Black/African-American • Cambodian • Chinese • Filipino • Guamanian	• Hawaiian • Hispanic/Latino • Japanese • Korean • Laotian • Samoan • Vietnamese • White • Other

14. Name of the Physician Who Treats your GHPP Eligible Condition: Write the name of the **physician who treats your GHPP eligible condition.**

14a. Treating Physician's address: Write the physician's street number, street name, city, county, **and zip code that treats your GHPP eligible condition.**

14b. Treating Physician's telephone number. Write the physician's telephone number, including **the area code that treats**

15. Name of your Special Care Center Facility. Write the name of your Special Care Center, if you have one.

16. Power of Attorney/Conservator information: If you have legally appointed someone to act as your Power of Attorney for health care, or if a conservator has been appointed for you, please write the name, title (i.e. Power of Attorney, Conservator), address, and telephone number for this individual. **You MUST attach documentation of this person's legal authority to act on your behalf if you wish for them to be able to communicate with the GHPP regarding your health care.**

**INSTRUCTIONS FOR COMPLETING
THE GENETICALLY HANDICAPPED PERSONS
PROGRAM (GHPP) APPLICATION TO DETERMINE
ELIGIBILTY**

Section B: Health Insurance Information: The GHPP is considered the payer of last resort. In other words, the GHPP will pay for your medically necessary health care only after any other health coverage you may have has paid.

17. Do you have Medi-Cal? Check the correct response (Yes or No).
- **a. If yes, what is your Beneficiary I.D. Card (BIC) number?** Write your Medi-Cal BIC I.D. number.

18. Do you have Medicare? Check the correct response (Yes or No).
- **a. If yes, what is your Medicare number?** Write your Medicare I.D.
- **b. Please check all Medicare programs in which you are enrolled:** Check all that apply (Parts A, B, C, D).

19. Do you have other health insurance? Check the correct response (Yes or No).
- **a. If yes,** Check the response which matches who your insurance is through and write the full name of your insurance company (i.e. Kaiser Permanente, Blue Cross of California, etc.).
- **b. Type of plan:** Check the response which matches the type of plan you have. NOTE: If you have an HMO, PPO or POS, please send a copy of your benefit booklet with your GHPP application.
- **c. Policy number/Coverage start date:** Write your health insurance policy number and the start date of your coverage.
- **d. Who pays for the policy?** Check the response which applies to your policy. If you check "Other" please specify who pays (i.e. Family).
- **e. When cost-effective, the HIPR Program may reimburse you for the cost of your third-party health coverage. Are you currently participating in the HIPR Program?** Check the correct response (Yes or No). **If yes, would you like the HIPR Program to continue reimbursing you?** Check the correct response (Yes or No) **If no, would you like reimbursement for your third-party health coverage premiums?** Check the correct response (Yes or No).
- **f. Has any of your insurance information changed?** If yes, please explain why.
- **g. If your employer provides health insurance and you choose not to participate in your employer's plan:** Check the response that explains why you choose not to participate. If you check "Other" please explain.
- **h. During the last six months from the date of this application, has either your employer or yourself terminated your employer's sponsored health insurance?** Check the correct response. If yes, include the date the insurance was terminated and the reason why it was terminated. If you check "Other" please explain.

**INSTRUCTIONS FOR COMPLETING
THE GENETICALLY HANDICAPPED PERSONS
PROGRAM (GHPP) APPLICATION TO DETERMINE
ELIGIBILTY**

20. Do you have

- **a. Dental Insurance?** Check the correct response (Yes or No). If Yes, write the name of the plan.
- **b. Vision insurance?** Check correct response (Yes or No). If Yes, write the name of the plan.

Section C: Certification: Read and initial the statements where indicated on the form. Then sign and date in ink, in the spaces provided. If you sign your name with an "X," you must have a witness sign in the space indicated.

Submitting your application: Email the application to GHPPEligibility@dhcs.ca.gov, or mail the completed form to the GHPP at: Genetically Handicapped Persons Program, MS 8100, P.O. Box 997413, Sacramento, CA 95899-7413.

GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP)
INITIAL/ANNUAL INCOME VERIFICATION

Refer to the Instructions on Page 6 through 9 When Filling in this Application

The following information is required by the GHPP to determine your enrollment fee amount, if any. Your enrollment fee is based upon your family gross income for the previous year. Your income information is reviewed annually, and therefore your enrollment fee may change from year to year.

Section A: Personal Information

1. Name (Last)	(First)	(MI)	2. Social Security Number
_____	_____	____	_____

3. Address (number, street, apartment #)	City	County	Zip Code
_____	_____	_____	_____

4. Telephone Number (Include Area Code)	5. Email Address
_____	_____

Section B: Income Verification

6. Family Gross Income
$ _____

7. List Income Data Source(s) and Attach

Copies

_____ _____

_____ _____

_____ _____

8. Family Size _____

List Family Members, Including Yourself, Who Are Dependent on the Family Income

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

(Use additional paper if more space is needed)

GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP)
INITIAL/ANNUAL INCOME VERIFICATION
Refer to the Instructions on Page 3 and 4 When Filling in this Application

9. Employment Information

Your Employer's Name _____

Employer's Telephone Number _____

Employer's Address _____

Section C: Enrollment Fee Information

NOTIFICATION OF ENROLLMENT FEE STATUS:

a. When the GHPP has calculated the amount of your enrollment fee, you will be sent a written notification. The total enrollment fee will be provided on an Enrollment Fee Agreement. The Enrollment Fee Agreement will specify the amount owed and two options for payment:

   i. One lump sum due no later than the 60th day from the date of notification from the GHPP, or

   ii. Two or three payments which are due no later than the 60th, 120th, and 180th days from the date of notification from the GHPP.

b. FAILURE TO PAY THE ENROLLMENT FEE ACCORDING TO THE SIGNED AGREEMENT WILL RESULT IN CLOSURE OF YOUR CASE ON THE 61ST, 121ST, OR 181ST DAY FROM THE DATE OF NOTIFICATION FROM THE GHPP.

Section D: Certification

Read and Initial Each Statement Below:

_____ I understand that my enrollment fee, if any, will be based on my stated income and that my enrollment fee may change annually if my income changes.

_____ I give my permission for the GHPP to verify my income and/or other circumstances which may be required to determine my annual enrollment fee, if any.

_____ I certify that I have read this information, or had it read to me, and that I understand it.

_____ I certify that the information I have given on this form is true and correct to the best of my knowledge.

GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP)
INITIAL/ANNUAL INCOME VERIFICATION

Refer to the Instructions on Page 3 and 4 When Filling in This Application

Section D: Certification

Read and Initial Each Statement Below:

_____ I understand that my enrollment fee, if any, will be based on my stated income and that my enrollment fee may change annually if my income changes.

_____I give my permission for the GHPP to verify my income and/or other circumstances which may be required to determine my annual enrollment fee, if any.

_____I certify that I have read this information, or had it read to me, and that I understand it.

_____I certify that the information I have given on this form is true and correct to the best of my knowledge.

Signature of GHPP Applicant/Client or Parent/ Legal Guardian of minor / child:	Relationship to Minor / Child:	Date:
_____	_____	_____

If Signing with an "X," Signature of Witness:	Relationship of Witness to GHPP Applicant/Client:	Witness Telephone Number:	Date:
_____			
Print name			
_____	_____	_____	_____

California law requires that families applying for services be given information on

how GHPP protects their privacy. [1] To protect your privacy:

- GHPP must keep this information confidential.[2]
- GHPP may share information on the form with authorized staff from other health and welfare programs **only** when you have signed a consent form.

You have the right to see your application and GHPP records concerning you. If you wish to see these records contact the GHPP at 1 (916) 552-9105 or toll free at 1 (800) 639-0597. By law, the information you give GHPP is kept by the program.[3]

INSTRUCTIONS FOR COMPLETING THE GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP) INITIAL/ ANNUAL INCOME VERIFICATION FORM

Please print clearly so your application can be processed as quickly as possible.

Please fill out each section completely. If you do not provide all the information requested, the GHPP will be unable to proceed with your application. If you need help in filling out this form, please contact the GHPP at 1 (916) 327-0470 or toll free at 1 (800) 639-0597. Once the application is completed, email it to the GHPP inbox GHPPEligibility@dhcs.ca.gov, or mail the application to GHPP MS 4502, P.O. Box 997413, Sacramento, CA 95899-7413. **PLEASE REMEMBER TO SIGN AND DATE THE FORM.**

Section A: Personal Information: This includes identifying information and other information necessary to process this form.

1. **Name:** Write your last name, first name, and middle initial.

2. **Social Security Number (OPTIONAL):** Write your nine-digit Social Security Number.

3. **Address:** Write your residence street number, street name, apartment number, city, county, and zip code. Do not use a P.O. Box.

4. **Telephone Number:** Write the telephone number where you can be reached, including the area code.

5. **Email:** Write the email address where you can be reached.

Section B: Income Verification: Follow the instructions for each number below. Your enrollment fee, if any, will be based upon the information you provide.

6. **Family Gross Income:** This is information found on your tax forms 1040 and 540. You can also use your forms W-2 and/or other documents listed below in Item 7. You must include income from members of your family who are dependent on the family income. Use the income amount from the previous year. Examples:

   - If you are not claimed on anyone else's tax returns and you earn your own income, this is the amount you must report.
   - If you are married you must report both your income and the income of your spouse, even if you file separately.
   - If you live with a family member who claims you on their tax returns, you must use their income amount and supply copies of their tax returns.
   - YOU DO NOT have to include the income from members of your household such as roommates or siblings.

If you have questions about what income you must report, please contact the GHPP.

**INSTRUCTIONS FOR COMPLETING
THE GENETICALLY HANDICAPPED
PERSONS PROGRAM (GHPP) INITIAL/
ANNUAL INCOME VERIFICATION FORM**

7. **List income data source(s) and attach copies:** This means the document(s) you used to calculate the amount listed in Item
6. Attach a copy of your **Federal Tax Form 1040** and any of the following documents used to calculate your family gross income.

- Social Security income statement
- Disability income statement
- Forms W-2
- Pay stubs
- Other (please specify)

8. **Family size:** List members of your household who are dependent on the family income. Your family size is considered when calculating your enrollment fee. Attach an additional sheet if more space is needed.

9. **Employment information:** List your employer's name, telephone number, and address.

Section C: Enrollment Fee Information: Read this important information about your enrollment fee.

Section D: Certification: Read and initial the statements where indicated on the form. Then sign and date in ink in the spaces provided. If you sign your name with an "X," you must have a witness sign in the space indicated.

Submitting your application: Email the completed form to GHPPEligibility@dhcs.ca.gov, or mail the completed form to the GHPP at: Genetically Handicapped Persons Program, MS 8100, P.O. Box 997413, Sacramento, CA 95899-7413.

1) Civil Code, Section 1798.17
2) In accordance with Section 41670, Title 22, California Code of Regulations and the California Public Records Act (Government Code, Sections 6250-6255)
3) Section 123800 et. seq. of the California Health and Safety Code

IEHP Lab Order Form

INLAND EMPIRE HEALTH PLAN
A Public Entity

Claims Remittance To:
IEHP
Claims Department – Vision
PO Box 4349
Rancho Cucamonga, CA 91729-4349

Member Name:	Member ID#:	Auth#:	Order Date:
Date of Birth:	Tray#:	Date Received:	

	SPHERE	CYLINDER	AXIS	PD FAR	PD NEAR	PRISM	BASE
R							
L							

CHECK APPROPRIATE LENS STYLE

SINGLE VISION	BIFOCAL		TRIFOCAL	MATERIAL
☐ SINGLE VISION V2100	☐ ROUND 22 V2200-28	☐ FLAT 28 V2200-28 ☐ FLAT 35 V2200-35	☐ FLAT 7X28 50% Intermed V2300	☐ CR-39 ☐ GLASS

	ADD	SEG HEIGHT	TINT: *Must include medical justification in special instructions
R			☐ UV V2755 ☐ PNK 1 2 V2740 ☐ BRN 1 2 3 V2740 ☐ GRY 1 2 3 V2740 ☐ PGX V2799-SV V2799-BI
L			☐ Frame Enclosed ☐ New Frame ☐ Used Frame

Frame Manufacturer	Frame Style	Eye Size	Bridge Size	Temple	Color

Add Ons (VER REQUIRED)

☐ VIP X/L Progressives V2781
☐ Scratch Resist V2760
☐ Spectralite S0590-SV/S0590-BI
☐ Multi-Layer Anti-Glare V2750
☐ Plastic Photochromic V2744
☐ 1.60 S0581-SV/S0581-BI
☐ Polycarbonate S0580-SV/S0580-BI
☐ Other_____

* Do not send case, straps, or specialty attachments with frame(s)

Special Instructions: (Include medical justification for tint and/or special instructions for lab)

PROFESSIONAL SIGNATURE:	DATE OF SERVICE:	TELEPHONE: ( )

Lab Copy
Lab Billing Copy
Packing Slip/Mailing Label
Doctor's Copy

SHIP TO:

Inland Empire Health Plan

In School Behavioral Health Treatment Services Request Form

I. GENERAL INFORMATION:

First Name:		**Last Name:**	
Birth Date:		**IEHP Member ID#:**	
Present Address:			
Parent/Guardian:		**Phone:**	
Language:		**Referral Date:**	
Request Date:		**Requestor/Certification:**	

Behavioral Health Treatment (BHT) services include applied behavioral analysis and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. The goal is to promote, to the maximum extent practicable, the functioning of a beneficiary, including those with or without ASD. Examples of BHT services include behavioral interventions, cognitive behavioral intervention, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training, peer training, pivotal response training, schedules, scripting, self-management, social skills package, and story-based interventions.[1]

a. School Information-

Within this section list the Member's school information: Grade Level, School placement (e.g., General Education Class, Specialized Academic Support, Autism Program, Mild/Moderate, Moderate/Severe, or Non-Public School), School name, School attendance days and hours, frequency and duration of related services provided by the school district (e.g., Occupational therapy, Speech Therapy, Physical Therapy, Adaptive Physical Education, Counseling, Nursing, Applied Behavior Analysis).

b. School District:

1) School districts are required under Section 504 of the Rehabilitation Act of 1943 and Title II of the American Disabilities Amendments Act to provide qualified students with disabilities with "Free Appropriate Public Education: (FAPE)". Children who require special education services including ABA services are entitled to receive these services as specified in the Individualized Education Plan (IEP). The school district will provide the necessary services either through district employees, or by contracting with a provider.

2) If a parent requests private applied behavioral analysis services (funded through the members health insurance) on school grounds during the school day, the school district will do the following:

   2.1 If the child is eligible for special education, an IEP team will meet to discuss whether the child requires an ABA provider at school in order to receive a Free Appropriate Public Education (FAPE), if the child does require this service the school district shall provide it to the child through his or her IEP.

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 19-014 Supersedes APL 18-006, "Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21"

2.2 If the child does not require an ABA provider in order to receive a (FAPE), or if the child is not eligible under the Individuals with Disabilities Education Act (IDEA) but has a disability, the school district will schedule an interactive meeting with the parents to determine whether the requested accommodation is reasonable. An accommodation is not reasonable if it fundamentally alters the nature of the school program or constitutes an undue burden. Information to be considered during the interactive meeting would include, for example, which services were prescribed by the physician or clinical psychologist, are the services addressing medical or educational needs, what are the disability related need(s) addressed by the services, what will the ABA provider do at school. If the school district agrees to allow privately funded ABA services on campus to address non-educational needs, it will be scheduled during recess or after school. A formal written agreement signed by the parents and private ABA provider will outline expectations of the private ABA provider, including but not limited to clarifying the scope of services, fingerprinting, background checks, procedures when entering and exiting campus, minimum insurance coverage, liability supervision, and other pertinent terms to protect the school district and other students on campus. In conclusion, ABA services may be provided on-campus when approved by the school district after consideration of the above.

IEHP:

A. In an effort to not duplicate services, providers who are requesting that BHT services be rendered in a school setting shall provide Inland Empire Health Plan with information on services already being funded by the School District or Regional Center. Any portion of medically necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and in the community.

B. IEHP will provide medically necessary BHT services to address the Member's needs not covered under the Local Education Authority (LEA) mandate to correct or ameliorate any conditions.

C. IEHPs Behavioral Health Department may also request the Member's IEP, 504 or any other school documentation that the provider possesses prior to authorizing in school services.

D. This form shall be updated annually with new requests (each school year) and/ or with any changes made to the Member's school services and/or accommodations.

According to All Plan Letter (APL) 19-014 Members must meet the criteria as stated below:

A. A Medi-Cal Member under 21 and have a recommendation from a licensed physician, surgeon or psychologist that evidence based BHT services are medically necessary.
B. Be medically stable; and

C. Not have a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities.

II. Recommendations: *Within this section provide a summary of the clinical recommendations (including clinical justification) for the Member. This should include the rational for* ***MEDICALLY NECESSARY AND CLINICALLY JUSTIFIED*** *behavioral health treatment.*

Parent Name Print

SIGNATURE REQUIRED

Parent Name Signature

Date

SIGNATURE REQUIRED

Name
Title
Agency Name

Date:

Medi-Cal Approved Centers of Excellence (COE) for Transplantation

Transplant Type	COE	Location	Adult (18 years old and above)	Pediatric (Less than 21 years old)
Bone Marrow	Cedars-Sinai Medical Center	Los Angeles	Y	
Bone Marrow	Children's Hospital of Los Angeles	Los Angeles		Y
Bone Marrow	Children's Hospital of Orange County	Orange		Y
Bone Marrow	Children's Hospital, Oakland	Oakland		Y
Bone Marrow	City of Hope National Medical Center	Duarte	Y	Y
Bone Marrow	Loma Linda University Medical Center	Loma Linda		Y
Bone Marrow	Rady Children's Hospital	San Diego		Y
Bone Marrow	Scripps Blood and Marrow Transplant Program	La Jolla	Y	
Bone Marrow	Stanford Medical Center	Palo Alto	Y	
Bone Marrow	Stanford-Lucile Packards Children's Hospital	Palo Alto		Y
Bone Marrow	Sutter Medical Center	Sacramento	Y	
Bone Marrow	University of California, Davis	Sacramento	Y	
Bone Marrow	University of California, Irvine	Irvine	Y	
Bone Marrow	University of California, Los Angeles	Los Angeles	Y	Y
Bone Marrow	University of California, San Diego	San Diego	Y	
Bone Marrow	University of California, San Francisco	San Francisco	Y	Y
Bone Marrow	University of Southern California, Norris Cancer Center	Los Angeles	Y	
Heart	California Pacific Medical Center	San Francisco	Y	
Heart	Cedars-Sinai Medical Center	Los Angeles	Y	
Heart	Children's Hospital of Los Angeles	Los Angeles		Y
Heart	Keck Hospital of University of Southern California	Los Angeles	Y	
Heart	Loma Linda University Medical Center	San Bernadino	Y	Y
Heart	Rady Children's Hospital	San Diego		Y
Heart	Sharp Memorial Hospital	San Diego	Y	
Heart	Stanford Medical Center	Palo Alto	Y	
Heart	Stanford-Lucile Packard Children's Hospital	Palo Alto		Y
Heart	Sutter Memorial Hospital	Sacramento	Y	
Heart	University of California, Los Angeles	Los Angeles	Y	Y
Heart	University of California, San Diego	San Diego	Y	
Heart	University of California, San Francisco	San Francisco	Y	

Transplant Type	COE	Location	Adult (18 years old and above)	Pediatric (Less than 21 years old)
Intestinal	Children's Hospital of Los Angeles	Los Angeles		Y
Intestinal	Stanford-Lucile Packard Children's Hospital	Palo Alto		Y
Intestinal	University of California, Los Angeles	Los Angeles	Y	
Kidney-Pancreas	California Pacific Medical Center	San Francisco	Y	
Kidney-Pancreas	Loma Linda University Medical Center	Loma Linda	y	
Kidney-Pancreas	University of California, Irvine	Irvine	Y	
Kidney-Pancreas	University of California, San Francisco	San Francisco	Y	
Liver	California Pacific Medical Center	San Francisco	Y	
Liver	Cedars-Sinai Medical Center	Los Angeles	Y	
Liver	Children's Hospital of Los Angeles	Los Angeles		Y
Liver	Keck Hospital, University of Southern California	Los Angeles	Y	
Liver	Loma Linda University Medical Center	San Bernadino	Y	
Liver	Scripps Green Hospital	San Diego	Y	
Liver	Stanford Medical Center	Palo Alto	Y	
Liver	Stanford-Lucile Packard Children's Hospital	Palo Alto		Y
Liver	University of California, Los Angeles	Los Angeles	Y	Y
Liver	University of California, San Diego	San Diego	Y	
Liver	University of California, San Francisco	San Francisco	Y	Y
Lung	Cedars-Sinai Medical Center	Los Angeles	Y	
Lung	Keck Hospital, University of Southern California	Los Angeles	Y	
Lung	Stanford Medical Center	Palo Alto	Y	
Lung	Stanford-Lucile Packard Children's Hospital	Palo Alto		Y
Lung	University of California, Los Angeles	San Angeles	Y	
Lung	University of California, San Diego	San Diego	Y	
Lung	University of California, San Francisco	San Francisco	Y	

Table 1: Medi-Cal Transplant Center of Excellence by Transplant Type and Adult/Child

Medi-Cal Approved Centers of Excellence (COE) for Transplantation

Centers are listed by type of organ transplant. Transplant program Surgical (S) or Medical (M) Director, and program contact names follow the facility name. Only Medical Directors are listed for Bone Marrow Transplant Centers. Adult applies to facilities approved for beneficiaries > 18 years old (y.o.); Pediatric applies to facilities approved for beneficiaries < 21 y.o. Beneficiaries referred to Integrated Systems of Care Division (ISCD)/California Children's Services (CCS) Program staff by Medi-Cal approved COEs for pediatric transplant are case managed by ISCD Branch/CCS Program staff.

Bone Marrow Transplants (BMT)

BMT contacts are administrative and quality control. Medical Directors are from the FACT roster for California

Adult-Only BMT Transplants

Cedars-Sinai Medical Center (Los Angeles)
Contact: Nancy Eng
Email: Nancy.Eng@cshs.org
Telephone: 310-423-2107
Medical Director: Ronald Parquette, MD

Scripps (La Jolla)
Contact: Michelle Meyer
Email: Meyer.Michelle@scrippshealth.org
Telephone: 858-554-4340
Head, Division of Oncology: James Mason, MD

Stanford Medical Center (Palo Alto)
Contact: Tawny Wong Lough, Division Manager
Email: tawnyw@stanford.edu
Telephone: 650-725-1715
Medical Director: Robert Negrin, MD

Sutter Medical Center (Sacramento)
Contact: Yuliya Smirnov, Clinical Program Quality Manager
Email: SmirnoY@sutterhealth.org
Telephone: 916-454-6512
Medical Director: Michael P Carroll, MD

Adult-Only BMT Transplants, continued

University of California, Davis (Sacramento)
Contact: Carol Richman, MD
Email: cmrichman@UCDAVIS.EDU
Telephone: 916-734-3772
Medical Director: Carol Richman, MD

University of California, Irvine (Irvine)
Contact: Stefan Ciurea, MD
Email: sciurea@hs.uci.edu
Telephone: 714-509-2290
Medical Director: Stefan Ciurea, MD

University of California, San Diego (La Jolla)
Contact: Patti Kicak
Email: pkicak@ucsd.edu
Telephone: 858-822-6393
Medical Director: Edward (Ted) Ball, MD

University of Southern California, Norris Cancer Center (Los Angeles)
Contact: Sosy Fincher, RN, MSN, AOCN, CNS; Director of Operations
Email: Sosy. Fincher@med.usc.edu
Telephone: 323-865-0904
Medical Director: Preet M. Chaudary, MD

Pediatric-Only BMT

Children's' Hospital of Los Angeles (Los Angeles)
Contact: Rafael Bravo Lopez , Quality Improvement Coordinator II
Email: Rblopez@chla.usc.edu
Telephone: 323-361-8570
Medical Director: Neena Kapoor, MD

Children's Hospital of Orange County (Orange)
Contact: Barbara Knight, Quality and Accreditation Coordinator
Email: bknight@choc.org
Telephone: 714-509-9315
Medical Director: Rishikesh Chavan, MD

Pediatric-Only BMT, continued

Children's Hospital, Oakland (Oakland)
Contact: Nancy Noonan
Email: nnoonan@mail.cho.org
Telephone: 510-428-3885 x 2835
Program Director/Medical Director: Mark Walters, MD
Program Director, per FACT: Shannon Kelly, MD

Loma Linda University Medical Center (Loma Linda)
Contact: Mojtaba Akhtari, MD, FACP [Adult COE application received– issues]
Email: Not available
Telephone: 951-290-6379
Medical Director, Adult: Wesley Tait Stevens, MD
Medical Director, Pediatric: Albert Kheradpour, MD

Rady Children's Hospital (San Diego)
Contact: Liz Sheldon, Rn, CPNP, PCNS, CPHON, Nurse Practitioner/BMT QA
Email: ESheldon@rchsd.org
Telephone: 858-576-1700 x 3676
Medical Director: Edward Ball, MD

Stanford – Lucile Packard Children's Hospital (Palo Alto)
Contact: Angela Koptksy
Email: akopetsky@stanfordchildrens.org
Telephone: 650-723-0310
Medical Director: Robert Negrin, MD [FACT]

Adult and Pediatric BMT

City of Hope National Medical Center (Duarte)
Contact: Joel Ricafort
Email: jricafort@coh.org
Telephone: 626-218-8762
Medical Director: Stephen J. Forman, MD

University of California, Los Angeles (Los Angeles)
Contact: Heather Steinmetz, MPH, QA Manager – HMSCT Program
Email: hsteinmetz@mednet.ucla.edu
Telephone: 310-267-8274
Medical Director: Gary Schiller, MD, FACP

Adult and Pediatric BMT, continued

University of California, San Francisco (San Francisco)
Contact: Erwin Carino, Quality Manager
Email: Erwin.Carino@ucsf.edu
Telephone: 415-353-4131
Medical Director, Adult: Thomas Martin, MD
Program Director, Pediatrics: Sandhya Kharbanda, MD

Heart Transplant COEs

Adults-only Heart Transplant

California Pacific Center (San Francisco)
Contact: Christine Moyle (Administrative Director)
Email: moylec@sutterhealth.org
Telephone: 415-600-1128
Program Director: Mic Brett Sheridan, MD
Primary Physician: Michael Pham, MD
Primary Surgeon: Brett Sheridan, MD

Cedars Sinai Medical Center (Los Angeles)
Contact: Robert Luga
Email: bert.iuga@cshs.org
Telephone: 310-423-6707
Program Director: Jon Kobashigawa, MD
Primary Physician: Jon Kobashigawa, MD
Primary Surgeon: Faradad Esmailian, MD

Keck Hospital of University of Southern California
Contact: Megan Bell, Director, Clinical Operations
Email: Megan.Bell@med.usc.edu
Telephone:
Program Director: Mark Cunningham, MD
Primary Physician: Eugene C. Depasquale, MD
Primary Surgeon: Mark Cunningham, MD

Adults-only Heart Transplant, continued

Sharp Memorial Hospital (San Diego)
Contact: Cindy Walsh
Email: Cynthia.Walsh@sharp.com
Telephone: 858-939-5009
Program Director: Robert Adamson, MD
Primary Physician: Brian Jaski, MD
Primary Surgeon: Robert Adamson, MD

Stanford Memorial Hospital (Palo Alto)
Contact: Christine Hartley, Administrative Director
Email: chartley@stanfordhealthcare.org
Telephone: 650-498-6185
Program Director: Pillip Oyer, MD
Primary Physician: Jeffery Teuteburg, MD
Primary Surgeon: Joseph Woo, MD

Sutter Memorial Hospital (Sacramento)
Contact: Dee Sanchez
Email: dsanchez@saccardio.com
Telephone: No phone number listed
Program Director: Robert Kincade, MD
Primary Physician: John Chin, MD
Primary Surgeon: Robert Kincade, MD

University of California, San Diego (San Diego)
Contact: Deepa Kurup
Email: dkurup@health.ucsd.edu
Telephone: No phone number listed
Medical Director: Gert Pretorius, MD
Primary Physician: Eric D Adler, MD
Primary Surgeon: Gert Pretorius, MD

University of California, San Francisco (San Francisco)
Contact: Anna Mello,Transplant Quality Manger
Email: anna.mello@ucsf.edu
Telephone: 415-203-7720
Program Director: Teresa De Marco, MD
Primary Physician: Teresa De Marco, MD
Primary Surgeon: Georg Wieselthaler, MD

Pediatrics-Only Heart Transplant

Children's Hospital of Los Angeles (Los Angeles)
Contact: Rosa Holguin
Email: rholguin@chla.usc.edu
Telephone: 323-361-8746
Program Director: Not listed
Primary Physician: Jon David Menteer, MD
Primary Surgeon: Cynthia Herrington, MD

Rady's Children's Hospital (San Diego)
Contact: Emily A Fletcher
Email: EFletcher1@rchsd.org
Telephone: 858-966-5855 x 7995
Program Director: Rakesh Singh, MD
Primary Physician: Gabrielle Vaughn, MD
Primary Surgeon: John Nigro, MD

Stanford – Lucille Packard Children's Hospital (Palo Alto)
Contact: Joshua E. Gossett
Email: jgossett@stanfordchildrens.org
Telephone: 650-363-0684
Program Director: Seth Adam Hollander, MD
Primary Physician: David Rosenthal, MD
Primary Surgeon: Teimour A Nasirov, MD

Adults and Pediatrics Heart Transplants

Loma Linda University Medical Center (San Bernardino)
Contact: Melissa Robinson, Quality & Safety Manager
Email: mnrobinson@llu.edu
Telephone: 909-558-3655 x 36746
Medical Director Liset Stoletniy, MD
Primary Physician: Liset Stoletniy, MD
Primary Surgeon: Joshua Chung, MD

University of California, Los Angeles (Los Angeles)
Contact: Nicholas J. Feduska, Jr., Assistant Director, Transplant Services
Email: nfeduska@mednet.ucla.edu
Telephone: 310-267-9047
Program Director, Adult: Ali Nsair, MD
Primary Physician: Ali Nsair, MD
Primary Surgeon: Abbas, Ardelhali, MD

Intestinal Transplants COEs

Adults-only Intestinal Transplants

University of California, Los Angeles (Los Angeles)
Contact: Nicholas J. Feduska, Jr., Assistant Director, Transplant Services
Email: nfeduska@mednet.ucla.edu
Telephone: 310-267-9047
Program Director: Robert Venick, MD
Primary Physician: Robert Vinick, MD
Primary Surgeon: Doulas Farmer, MD

Pediatrics-Only Intestinal Transplants

Children's Hospital of Los Angeles (Los Angeles)
Contact: Stephanie Johnson, Administrator, Transplant Services
Email: sjohnson@chla.usc.edu
Telephone: 323-361-6380
Program Director: Yuri, Genyk, MD
Primary Physician: Rohit Kohli, MD
Primary Surgeon: Kambiz Etesami, MD

Stanford – Lucille Packard Children's Hospital (Palo Alto)
Contact: Joshua E. Gossett
Email: jgossett@stanfordchildrens.org
Telephone: 650-363-0684
Program Director: Carlos Esquivel, MD
Primary Physician: William Berquist, MD
Primary Surgeon: Clark Bonham, MD

Kidney-Pancreas Transplant COEs

Adults-Only

Californian Pacific Medical Center (San Francisco)
Contact: Christine Moyle, Administrative Director
Email: moylec@sutterhealth.org
Telephone: 415-600-1128
Program Director, Kidney: William I. Bry
Primary Physician, Kidney: Steven Katznelson
Primary Surgeon, Kidney: William I. Bry
Program Director, Pancreas: Parul S. Patel, MD/ Harish Mahanty, MD
Primary Physician, Pancreas: Parul S. Patel, MD
Primary Surgeon, Pancreas: Harish Mahanty, MD

Loma Linda University Medical Center (San Bernardino)
Contact: Melissa Robinson, Quality & Safety Manager
Email: mnrobinson@llu.edu
Telephone: 909-558-3655 x 36746
Program Director: Rafael Villicana, MD/ Charles F Bratton, MD
Primary Physician, Kidney: Rafael Villicana, MD
Primary Surgeon, Kidney: Charles F Bratton, MD
Primary Physician, Pancreas: Rafael Villicana, MD
Primary Surgeon, Pancreas: Charles F Bratton, MD

University of California Irvine (Irvine)
Contact: Anthony Palanca
Email: apalanca@hs.uci.edu
Telephone: 714-456-7472
Medical Director, Kidney: Uttam G Reddy, MD
Tranplant Program Director, Kidney: Hirohito Ichii, MD
Primary Physician, Kidney: Uttam G Reddy, MD Hirohito Ichii, MD
Primary Surgeon, Kidney: Hirohito Ichii, MD
Tranplant Program Director, Pancreas: Hirohito Ichii, MD
Primary Physician, Pancreas: Uttam G Reddy, MD
Primary Surgeon, Pancreas: Hirohito Ichii, MD

University of California San Francisco Medical Center (San Francisco)
Contact: Anna Mello, Transplant Quality Manager
Email: anna.mello@ucsf.edu
Telephone: 415-203-7720
Medical Director, Kidney: Deborah Adey, MD
Tranplant Program Director, Kidney: John P Roberts, Deborah Adey, MD
Primary Physician, Kidney: Deborah Adey, MD

Primary Surgeon, Kidnely: Chris E. Freise, MD
Tranplant Program Director, Pancreas: Peter G. Stock, MD/Flavio Vicenti, MD
Primary Physician, Pancreas: Minnie Sarwal, MD
Primary Surgeon, Pancreas: Peter G. Stock, MD

Liver Transplant COEs

Adults-Only Liver Transplants

California Pacific Medical Center (San Francisco)
Contact: Christine Moyle, Administrative Director
Email: moylec@sutterhealth.org
Telephone: 415-600-1128
Programl Director: Raphael B. Merriman, MD
Primary Physician: Raphael Merriman, MD
Primary Surgeon: Robert Osario, MD

Cedars-Sinai Medical Center (Los Angeles)
Contact: Robert Luga
Email: robert.iuga@cshs.org
Telephone: 310-423-6707
Programl Director: Walid Ayoub, MD
Primary Physician: Alexander, Kuo, MD
Primary Surgeon: Nocholas Nissen, MD

Keck Hospital of University of Southern California (Los Angeles)
Contact: Megan Bell, Director, Clinical Operations
Email: Megan.Bell@med.usc.edu
Telephone:
Program Director: Yuri Genyk, MD
Primary Physician: Jeffrey Kahn, MD
Primary Surgeon: Yuri Genyk, MD

Loma Linda University Medical Center (San Bernardino)
Contact: Melissa Robinson, Quality & Safety Manager
Email: mnrobinson@llu.edu
Telephone: 909-558-3655 x 36746
Program Director: Michael L. Volk, MD
Primary Physician: Michael L. Volk, MD
Primary Surgeon: Michael De Vera, MD

Adults-Only Liver Transplants, continued

Scripps Green Hospital (San Diego)
Contact: Michelle Meyer
Email: meyer.michelle@scrippshealth.org
Telephone: 858-554-4340
Medical Director: Catherine Frenette, MD
Primary Physician: Catherine Freneete, MD
Primary Surgeon: Christopher Marsh, MD
Adults-Only Liver Transplants – continued

Stanford Medical Center (Palo Alto):
Contact: Christine Hartley, Administrative Director
Email: chartley@stanfordhealthcare.org
Telephone: 650-498-6185
Program Director: Aijaz Ahmed, MD
Primary Physician: Aijaz Ahmed, MD
Primary Surgeon: Carlos Esquival, MD

Liver Transplants, Adult-Only, conitnued

University of California, San Diego (San Diego)
Contact: Deepa Kurup
Email: dkurup@health.ucsd.edu
Telephone: No phone number listed
Program Director: Kristin Mekel, MD
Primary Physician: Rohit Loomba, MD
Primary Surgeon: Gabriel Schnickel, MD

Pediatrics-Only Liver Transplants

Children's Hospital of Los Angeles (Los Angeles)
Contact: Rosa Holguin
Email: rholguin@chla.usc.edu
Telephone: 323-361-8746
Program Director: Yuri Genyck, MD
Primary Physician: Beth Carter, MD
Primary Surgeon: Yuri Genyck, MD

Stanford-Lucile Packard Children's Hospital (Palo Alto)
Contact: Joshua E. Gossett
Email: jgossett@stanfordchildrens.org
Telephone: 650-363-0684
Medical Director: William Berquist, MD

Primary Physician: W illiam Berquist, MD
Primary Surgeon: Carlos Equivel, MD

Adults and Pediatrics Liver Transplants

University of California, Los Angeles (Los Angeles)
Contact: Nicholas. J. Feduska, Assistant Director
Email: nfeduska@mednet.ucla.edu
Telephone: 310-267-9047
Program Director: Ronald Busitil, MD
Primary Physician: Sammy Saab, MD
Primary Surgeon: Ronald Busitil, MD

University of California, San Francisco (San Francisco)
Contact: Anna Mello
Email: anna.mello@ucsf.edu
Telephone: 415-203-7720
Program Director: John Roberts, MD
Primary Physician: Francis Yao, MD
Primary Surgeon: John Roberts, MD

Lung Transplant COEs

Adults-Only Lung Transplants

Cedars Sinai Medical Center (Los Angeles)
Contact: Robert Luga
Email: robert.iuga@cshs.org
Telephone: 310-423-6707
Program Director: Danny Ramzy, MD
Primary Physician: Geoge Chaux, MD
Primary Surgeon: Danny Ramzy, MD

Adults-Only Lung Transplants, continued

Keck Hospital of University of Southern California (Los Angeles)
Contact: Megan Bell, Director, Clinical Operations
Email: Megan.Bell@med.usc.edu
Telephone:
Program Director: Sivagini Ganesh, MD
Primary Physician: Sivagini Ganesh, MD
Primary Surgeon: Michael McFadden, MD

Stanford Medical Center (Palo Alto):
Contact: Christine Hartley
Email: chartley@stanfordhealthcare.org
Telephone: 650-498-6185
Program Director: Gundeep Dhillon, MD
Primary Physician: Gundeep Dhillon, MD
Primary Surgeon: Joeseph Woo, MD

University of California, San Diego (San Diego)
Contact: Deepa Kurup
Email: dkurup@health.ucsd.edu
Telephone: No phone number listed
Medical Director: Eurgene Golts, MD
Primary Physician: Kamyar Ashfar, MD
Primary Surgeon: Eugene Golts, MD

University of California, San Francisco (San Francisco)
Contact: Anna Mello
Email: anna.mello@ucsf.edu
Telephone: (415) 203-7720
Program Director: Steve Hayes, MD
Primary Physician: Steve Hayes, MD
Primary Surgeon: Jasleen Kukreja, MD

University of California, Los Angeles (Los Angeles)
Contact: Nicholas J. Feduska, Jr., Assistant Director, Transplant Services
Email: nfeduska@mednet.ucla.edu
Telephone: 310-267-9047
Program Director, Abbas Ardehali, MD
Primary Surgeon: David Sayah, MD

Pediatrics-Only Lung Transplants

Stanford-Lucile Packard Children's Hospital (Palo Alto)
Contact: Joshua E Gossett
Email: jgossett@stanfordchildrens.org
Telephone: 650-363-0684
Program Director: Carol Conrad, MD
Primary Physician: Carol Conrad, MD
Primary Surgeon: John MacArthur, MD

OPHTHALMOLOGIST REFERRAL FORM

DATE: _____

1A. OPTOMETRY TO OPHTHALMOLOGY REFERRALS ONLY

1. Fax a copy to the Member's IPA.
2. Place a copy in Member's medical record.
3. Fax a final copy back to the referring Optometrist

1B. REFERRAL TYPE

- ☐ GENERAL OPHTHALMOLOGY
- ☐ RETINA SPECIALIST
- ☐ PEDIATRIC OPHTHALMOLOGY

- ☐ **MEDICALLY URGENT**
- ☐ **ROUTINE –** Decision in five (5) working days
- ☐ **Patient Request**

2. GENERAL INFORMATION

Member Name (please print)	DOB	ID #

Plan (*select one*)		**Parent/Guardian/Caretaker name (REQUIRED)**
☐ Medi-Cal ☐ IEHP DualChoice		

Address	City	Zip	Phone

Diagnosis	**ICD-10 Code (REQUIRED)**

Clinical justification for referral (and description of procedure requested if any) *REQUIRED

Referring Provider (please print)	Phone	Fax

Address	City	Zip

Referring Provider Signature (REQUIRED)	Office Contact Person	

3. COMPLETED BY IPA

Ophthalmologist Referred (please print)		Appointment Date	Phone

Address	City	Zip	Fax

☐ Office ☐ Outpatient	**CPT Code (REQUIRED)**			
Date Additional Information Requested:	Date Additional Information Received:	☐ Approved	☐ Modified	☐ Denied

Medical Reviewer Comments

IF YOU WOULD LIKE TO DISCUSS THIS DECISION WITH THE PHYSICIAN REVIEWER, PLEASE CONTACT THE IPA:

IPA NAME: **Phone: ( ) -**

Medical Reviewer Signature (Circle Title: MD, DO, OD, RN, LVN, Coordinator)	Date/Time	Criteria utilized in making this decision are available upon request by calling **IEHP – Provider Relations at (909) 890-2054**.

UPON ACCEPTANCE OF REFERRAL AND TREATMENT OF THE MEMBER, THE PHYSICIAN/PROVIDER AGREES TO ACCEPT IPA CONTRACTED RATES. This referral/authorization verifies medical necessity only. Payments for services are dependent upon the Member's eligibility at the time services are rendered.

FAX COMPLETED REFERRAL FORMS TO THE MEMBER'S IPA.

INLAND EMPIRE HEALTH PLAN

PCP VISION REPORT

TO BE COMPLETED BY THE VISION PROVIDER

Exam Date: _____

Member's Name: _____ DOB: _____

Member's IEHP ID#: _____

☐ CHECK HERE IF MEMBER WAS REFERRED BY THE PCP

FROM:

Vision Provider: _____ Phone: _____

Address: _____ City: _____ Zip: _____

TO: **Forwarded by:** **MAIL** ☐ **FAX** ☐

PCP: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____

EXAMINATION FINDINGS

CHECK ALL THAT APPLY:

☐ This was a dilated ***Diabetic Retinal Examination (DRE)*** using a binocular indirect ophthalmoscope to rule out diabetic eye disease. Examination results are as follows:

☐ **Normal Findings** ☐ **Other** ***(please complete section below)***

☐ This was a medical eye visit for evaluation, treatment and management of an acute ocular condition:

(please complete section below)

Symptoms (detail): _____

_____

Diagnosis: _____ **ICD Code:** _____

Procedures / Treatment Plan: _____

_____

Recommendations: _____

Vision Provider: _____ **Date:** _____ **Next Visit:** _____

(signature)

Copy To PCP

Copy Vision Provider File

A Public Entity
Inland Empire Health Plan

Transplant Team Referral Form

Name of Form Submitter: _____

Date of Submission: _____

Phone number of Submitter: _____

Include the following with Transplant Team Referral Form submission:

1. Copy of approved authorization
2. Clinical documentation submitted with authorization request

Fax this Transplant Team Referral Form, approved authorization, and clinical documentation to the IEHP Transplant Team at 909-477-8542.

For inquiries, please contact the IEHP Provider Relations Team at (866) 725-4347. Thank you.