5. MEDICAL CARE STANDARDS

A. Initial Health Assessment

APPLIES TO:

A. This policy applies to IEHP Covered Members and Providers.

POLICY:

A. IEHP ensures that all new Members have an Initial Health Assessment (IHA) completed during the Member's initial encounter(s) with their Primary Care Provider (PCP).

DEFINITION:

A. Initial Health Assessment (IHA) – The IHA is a comprehensive assessment that is completed during the Member's initial encounter(s) with a selected or assigned Primary Care Provider (PCP), appropriate medical specialist, or non-physician medical provider (NPMP) that is documented in the Member's medical record. The IHA consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA)/ Staying Health Assessment (SHA). The IHA enables the Member's PCP to assess and manage the acute, chronic, and preventive health needs of the Member and identify those Members whose health needs require coordination with appropriate community resources and other agencies.

PROCEDURES:

Components of the IHA

A. An IHA consists of the following components:
   1. History of present illness;
   2. Behavioral history - review of pertinent health related behaviors including smoking, alcohol and drug use, exercise, etc.;
   3. Review of past medical and social history;
   4. Review of systems - review of signs and symptoms related to all major organ systems;
   5. Review of current medication use;
   6. Review of preventive services - review of status of Member in terms of needed preventive services (e.g., immunizations, cervical cancer screening);
   7. Physical exam (including mental status) sufficient to assess the Member's acute, chronic, preventive health needs, and psychosocial needs;
   8. Dental screening/oral health assessment;
   9. Diagnostic tests - ordering of appropriate diagnostic tests, as needed; and
   10. Development of Problem List and Medication List, if appropriate.

Timelines for IHA Completion

A. IEHP Members are notified of the availability and need for their PCP to schedule and conduct the IHA within:

1. 60 calendar days of enrollment for Members under 18 months of age; or
2. 120 calendar days of enrollment for Members age 18 months and older.
3. If the member requests or the plan initiates a change in their PCP within the first one hundred 120 days of their enrollment with IEHP and the IHA has not yet been completed, an IHA still needs to be completed by the newly assigned PCP within the timeframes set forth in this policy.

Provider Responsibilities

A. PCPs are required to have specific policies and procedures in place to notify Members to come in for their IHA, timelines for its completion, and facilitate the Member's access to an IHA. PCPs may work in collaboration with their Plan to meet this requirement.

1. PCP offices must maintain documentation of these notifications (i.e., letters to all Members, active or not, informing them of the need for an IHA) for a minimum of 10 years. If the Member does access care and a chart is opened, the notification must be filed in the Member's medical record and maintained according to Policy 3A, "Provider Medical Record Requirements." If the Member never accesses care with the PCP, the office must still maintain the documentation according to the same policy.

B. PCPs are responsible for assessing Members of the need for an IHA and scheduling accordingly, any time they see the Member for an acute or chronic illness. If the Member has had an IHA within 12 months of their enrollment, the PCP must document the specifics in the Member's medical record.

C. PCPs are responsible for retaining the Member's completed IHA and IHEBA/SHA in the Member's medical record to be available during subsequent preventive health visits.

D. PCPs are responsible for accessing a current list of their Members eligible for an IHA through the secure IEHP Provider portal.

E. PCPs are responsible for follow-up of missed appointments, as outlined in Policy 4B, "Missed Appointments."

F. PCPs are responsible for providing preventive services at the time of IHA completion or arranging follow-up visits or referrals for Members that have significant health problems identified during the IHA. For information on age-specific preventive care guidelines and services, See Policies 5B, "Adult Preventive Services," 5C1, "Pediatric Preventive Services – Well Child Visits," and 5C2, "Pediatric Preventive Services – Immunization Services."

Provider Training

A. IEHP provides IHA training to all Providers and their staff regarding:

1. Adequate documentation of IHAs or the reasons IHAs were not completed;

2. Timelines for performing IHAs; and
3. Procedures to assure that visit(s) for the IHA are scheduled and that Members are contacted about missed IHA appointments.

Exceptions from IHA Requirements

A. Exceptions from the timeline requirements described in this policy can occur only in the following situations, and only if documented in the Member's medical record:

1. All elements of the IHA were completed within 12 months prior to the Member's enrollment with IEHP. If the PCP did not perform the IHA, he or she must document in the Member's medical record that the findings have been reviewed and updated accordingly.
2. For new plan Members who choose their current PCP as their new plan PCP, an IHA still needs to be completed within 120 days of enrollment. The PCP may incorporate relevant patient historical information from the Member's old medical record. However, the PCP must conduct an updated physical examination if the Member has not had a physical examination within 12 months of the Member's enrollment with IEHP.
3. The Member was not continuously enrolled with IEHP for one hundred twenty (120) days.
4. The Member was disenrolled from IEHP before an IHA could be performed.
5. The Member, including emancipated minors or a Member's parents or guardian, refuses an IHA. See "Attachment/DHCS MMCD Medical Record Review Standards" found on the IEHP website.[1]
6. The Member missed a scheduled PCP appointment and one (1) documented attempt to reschedule have been unsuccessful. Documentation must demonstrate good faith effort to update the Member's contact information and attempts to perform the IHA at any subsequent office visits, even if the deadline for IHA completion has elapsed.

Monitoring and Oversight

A. IEHP monitors PCPs' compliance with IHA requirements through the Medical Record Review (MRR) survey process. The MRR verifies that an IHA was completed based on whether the record contains a comprehensive history and physical, and an IHEBA.

B. As part of IEHP's oversight of the Plan's activities, quarterly IHA completion rates are reviewed and feedback is provided to the Plan on their IHA completion rate.

[1] https://www.providerservices.iehp.org/en/resources/provider-resources/forms

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	☐ DMHC	☐ NCQA
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5. MEDICAL CARE STANDARDS

B. Adult Preventive Services

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. For adult Members, Primary Care Providers (PCPs) are required to deliver Adult Preventive Services consistent with the most recent edition of the United States Preventive Services Task Force (USPSTF) guidelines, unless specified differently by IEHP. All preventive services with a grade of "A" or "B" must be offered or provided[1,2] and do not require prior authorization.[3]

B. IEHP requires all IEHP network Providers to provide immunization services according to the most recent U.S. Public Health Service's Advisory Committee on Immunization Practice (ACIP) recommendations.

DEFINITION:

A. Adverse Childhood Experience (ACE) – For the purpose of this policy, this is defined as events, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.[4]

PROCEDURES:

Health Assessments

A. PCPs are required to provide an Initial Health Assessment (IHA) within one hundred twenty (120) calendar days of enrollment to all Covered California Members assigned to them as outlined in Policy 5A, "Initial Health Assessment."

B. PCPs are required to provide targeted history and physical examinations focused on the needs and risk factors of Members on an annual basis. History and physical examinations must include, at a minimum:

   1. Comprehensive (initial) or interim medical history including history of illness, past medical history, social history, and review of organ systems;

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[1] California Health and Safety (Health & Saf.) Code § 1367.002(a)(1)
[2] U.S. Preventive Services Task Force (USPSTF) A and B Recommendations http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations
[3] Department of Managed Health Care (DMHC) All Plan Letter (APL) 23-009, "Health Plan Coverage of Preventive Services"
[4] California Health and Safety (Health & Saf.) Code § 1367.34(b)

2. Physical exam - Either comprehensive (initial) or targeted (interim) addressing all appropriate parts of the body and organ systems, including screening for high blood pressure, pulse, respiratory rate, temperature, height and weight, and BMI;
3. Dental screening – An oral survey for teeth, gum or oral cavity related illnesses or injuries; and
4. Vision and hearing screening as appropriate for age.

C. IEHP understands that in certain cases Members do not come in for the physical exams for reasons beyond their PCP's control. PCPs are therefore expected to make reasonable efforts to schedule the examinations for their assigned Members on an episodic basis. For Members that they have never seen, PCPs are required to actively outreach to Members when they first enroll to schedule the Initial Health Assessment within one hundred twenty (120) calendar days of their enrollment. See Policy 5A, "Initial Health Assessment."

D. If a Member does not receive the appropriate services as required, the PCP must document attempts made to contact the Member and the Member's non-compliance.

Adverse Childhood Experience (ACE) Screening

A. ACE screenings in all inpatient and outpatient settings are only reimbursable for contracted Providers who complete the certified core ACEs Aware online training and who self-attest that they have completed this training; and have used the ACE Questionnaire for Adults, which can be found in various languages at the ACES Aware website.[5]

B. The Provider must maintain the following documentation in the Member's medical record, and make these available to IEHP upon request:
   1. The screening tool that was used;
   2. That the completed screen was reviewed;
   3. The results of the screen;
   4. The interpretation of results; and
   5. What was discussed with the Member and/or family, and any appropriate actions taken.

Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)

A. SABIRT services may be provided by Providers in a primary care setting and within their scope of practice, including, but not limited to, physicians, physician assistants, nurse practitioners, certified nurse midwives, licensed midwives, licensed clinical social workers, licensed professional clinical counselors, psychologists and licensed marriage and family therapists. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.

B. PCPs, within their scope of practice, must provide SABIRT services for Members 11 years of

[5] https://www.acesaware.org/learn-about-screening/screening-tools/screening-tools-additional-languages/

age and older, including pregnant women as follows:

1. When the Member responds affirmatively to the alcohol pre-screen question on the SHA, the PCP must conduct screening for unhealthy alcohol and drug use using validated screening tools, including but not limited to:
   a. Alcohol Use Disorders Identification Test (AUDIT-C). See "Attachment/AUDIT-C" found on the IEHP website;[6]
   b. Brief Addiction Monitor (BAM). See "Attachment/Brief Addiction Monitor (BAM) With Scoring & Clinical Guidelines" found on the IEHP website;[7]
   c. Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID);
   d. Tobacco Alcohol, Prescription Medications and other Substances (TAPS);
   e. National Institute on Drug Abuse (NIDA) Quick Screen for Adults (The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening);
   f. Drug Abuse Screening Test (DAST-10);
   g. Parents, Partner, Past and Present (4Ps) for pregnant women; and
   h. Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population.

   See Policy 5C1, "Pediatric Prevention Services – Well Child Visits" for a list of validated tools for adolescents.

2. When the Member's screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or substance use disorder is present. Validated alcohol and drug assessment tools include, but are not limited to:
   a. Alcohol Use Disorders Identification Test (AUDIT);
   b. Brief Addiction Monitor (BAM). See "Attachment/Brief Addiction Monitor (BAM) With Scoring & Clinical Guidelines" found on the IEHP website;[8]
   c. NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST); and
   d. Drug Abuse Screening Test (DAST-20).

3. The PCP must offer immediate brief misuse counseling when a Member reveals unhealthy alcohol use. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to Members whose brief assessment demonstrates possible alcohol use disorder (AUD) or substance use disorder (SUD). Brief interventions must include the following:

[6] https://www.iehp.org/en/providers/provider-resources?target=forms
[7] Ibid.
[8] Ibid.

a. Providing feedback to the Member regarding screening and assessment results;

b. Discussing negative consequences that have occurred and overall severity of the problem;

c. Supporting the Member in making behavioral changes; and

d. Discussing and agreeing on plans for follow-up with the Member, including referral to other treatment if indicated.

4. The PCP must ensure the Member's medical record include the following:

   a. The service provided (e.g., screen and brief intervention);

   b. The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record);

   c. The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record); and

   d. If and where a referral to an AUD or SUD program was made.

5. IEHP will make good faith efforts to confirm whether Members receive referred treatments and document when, where, and any next steps following treatment. If a Member does not receive referred treatments, IEHP will follow up with the Member to understand barriers and make adjustments to the referrals as needed. IEHP may also attempt to connect with the Provider to whom the Member was referred to facilitate a warm hand-off to necessary treatment.

C. IEHP informs Members of SABIRT services through Member-informing materials, including but not limited to the Evidence of Coverage (EOC).

D. When a Member transfers from one PCP to another, the receiving PCP must attempt to obtain the Member's prior medical records, including those pertaining to the provision of preventive services.

E. IEHP complies with all applicable laws and regulations relating to the privacy of substance use disorder records. See Policy 3B, "Information Disclosure and Confidentiality of Medical Records," for more information.

Tobacco Prevention and Cessation

A. Providers must identify and track all tobacco use, both initial and annually, through the following activities:

   1. Completion of the IHA questionnaire, which asks about smoking status and/or exposure to tobacco smoke;

   2. Annual assessment of tobacco use based on the SHA periodicity schedule, unless an assessment needs to be readministered; and

3. Asking Members about their current tobacco use and documenting in their medical record at every visit.

B. Providers must review the questions on tobacco with the Member, which constitutes as individual counseling.

C. With regard to Members identified as using tobacco products, IEHP encourages Providers to implement the following interventional approach:

1. Providers are encouraged to use a validated behavior change model to counsel Members who use tobacco products. Training materials for the following examples may be requested from IEHP by calling the Provider Call Center at (909) 890-2054 or accessed online through the IEHP website at www.iehp.org:
   a. Use of the "5 A's" – Ask, Advise, Assess, Assist, and Arrange; and
   b. Use of the "5 R's" – Relevance, Risks, Rewards, Roadblocks, and Repetition.
2. Members are able to receive a minimum of four (4) counseling sessions of at least ten (10) minutes per session. Members may choose individual or group counseling conducted in person or by telephone.
   a. Individual, group, and telephone counseling is offered at no cost to Members who wish to quit smoking, whether or not those Members opt to use tobacco cessation medications.
3. Two (2) quit attempts per year are covered without prior authorization and without any mandatory breaks between quit attempts.
   a. The lists of appropriate Current Procedure Terminology (CPT) and International Classification of Diseases (ICD) codes for tobacco use may be accessed online through the IEHP non-secure Provider portal at www.iehp.org.
4. Members are to be referred to the California Smoker's Helpline (1-800-NO-BUTTS) or other comparable quit-line service. Providers are encouraged to use the Helpline's web referral, or if available in their area, the Helpline's e-referral system.

Immunizations

A. All Members must be assessed for and receive, if indicated, immunizations according to State and Federal standards. Immunizations are provided to all Members according to the most recent U.S. Public Health Service's Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule. See "Attachment/Recommended Adult Immunization Schedule" found on the IEHP website.[9,10]

B. Immunizations are preventive services not subject to prior authorization requirements.

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[9] https://www.iehp.org/en/providers/provider-resources?target=forms
[10] Centers for Disease Control (CDC) Adult Immunization Schedule https://www.cdc.gov/vaccines/schedules/index.html

C. IEHP requires network Providers to document each Member's need for ACIP-recommended immunizations as part of all regular health visits including, but not limited to, the following encounter types:

1. Illness, care management, or follow-up appointments;
2. Initial Health Assessments (IHAs);
3. Pharmacy services;
   a. Adult Members may receive vaccines through three (3) options, without a Prior Authorization (PA):
      1) Vaccination from a licensed medical Provider;
      2) Vaccination from a pharmacy in the Vaccine Network; and
      3) Vaccination from a Local Health Department.
4. Prenatal and postpartum care;
5. Pre-travel visits;
6. Sports, school, or work physicals;
7. Visits to a local health department (LHD); and
8. Well patient checkups.

D. Members may access LHDs for immunizations. IEHP will reimburse LHDs for the immunization administration fee.

E. Providers must report Member-specific immunization information to the immunization registry that is part of the Statewide Immunization Information System (e.g. CAIR2). Reports must be made after a Member's IHA and after all healthcare visits that result in an immunization. IEHP strongly recommends immunizations are reported within fourteen (14) days of administration.

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APPLIES TO:

A. This policy applies to all IEHP Covered Members and Providers.

POLICY:

A. IEHP requires all Primary Care Providers (PCPs) in the network to meet American Academy of Pediatrics (AAP), Advisory Committee on Immunization Practice (ACIP),[1] and Child Health and Disability Prevention (CHDP) guidelines for providing pediatric preventive services.[2] When applicable, IEHP will also use the latest recommendations from the U.S. Preventive Services Task Force (USPSTF).[3] These services do not require prior authorization.

DEFINITION:

A. Adverse Childhood Experience (ACE) – For the purpose of this policy, this is defined as events, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.[4]

PROCEDURES:

Health Assessments

A. IEHP requires its contracted PCPs to provide Periodic Health Assessments (PHA) according to the Recommendations for Preventive Pediatric Health Care that is based on the consensus statement from the AAP and Bright Futures. PCPs must complete the various components of the assessment according to the schedule, or more frequently as the Member's health status dictates.

B. The PHA must include the elements outlined by the Bright Futures/AAP recommendations. See "Attachment/Recommendation for Preventive Pediatric Health Care" found on the IEHP website:[5,6]

   1. Comprehensive health and developmental history (including assessment of both physical and mental health development);

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[1] Centers for Disease Control and Prevention, Advisory Committee on Immunization Practice (ACIP) Vaccine Recommendations and Guidelines - https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html
[2] California Health and Safety Code (Health & Saf. Code) § 1367.35
[3] United States Preventive Services Task Force (USPSTF), USPSTF A and B Recommendations - https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
[4] California Health and Safety (Health & Saf.) Code § 1367.34(b)
[5] https://www.iehp.org/en/providers/provider-resources?target=forms
[6] American Academy of Pediatrics, Recommendations for Preventive Pediatric Health Care - https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

2. Developmental screening tests should be performed with a validated instrument and administered at the well-child visit at 9, 18, and 30 months of age.
3. Unclothed physical examination with suitable draping for older children, including assessment of physical growth;
4. Body Mass Index (BMI);
5. Visual acuity screen is recommended annually at age 4 and 5 years, as well as in cooperative 3-year old;
6. Dental risk assessment and education to parents about oral health;
7. Hearing screening;
8. Blood pressure screening ages 3 years and older at each Well-Child visit and when clinically appropriate;
9. Updating and completing immunizations. See Policy 5C2, "Pediatric Preventive Services - Immunization Services;"
10. Tuberculosis testing, as indicated;
11. Testing for anemia, when appropriate;
12. Blood lead screening testing per the California Department of Public Health's Childhood Lead Poisoning Branch Prevention Branch (CLPPB) recommendations (https://www.cdph.ca.gov/programs/CLPPB/Pages/default.aspx);
13. Cholesterol screening;
14. Screening for diabetes;
15. Hepatitis B screening.

C. PCPs are responsible for providing all necessary treatment and/or diagnostic testing identified at the time of the health assessment that are within their scope of practice. For services needed beyond their scope of practice, PCPs are responsible for requesting and/or arranging necessary referrals to appropriate Practitioners either directly (e.g., behavioral health, substance abuse) or through their Plan (e.g., in-plan specialty referrals, specialized diagnostic testing).

D. Diagnosis and treatment of any medical conditions identified through any pediatric preventive services assessment must be initiated within 60) days of the assessment.

Initial Health Assessment

A. Initial Health Assessments (IHA) must be provided to all Members under age 18 months within 60 days of their enrollment, unless the PCP determines that the Member's medical record contains complete and current information consistent with the assessment requirements stated above. See Policy 10A, "Initial Health Assessment" for more information."

1. Requests for IHA can be made by the Member, their parent(s), or guardian. When a

request is made for an IHA, an appointment must be made for the Member to be examined within two (2) weeks of the request. If the child is due for a well child visit based on the well child periodicity schedule, the visit must be scheduled within two (2) weeks.

Blood Lead Screening Test

A. Providers must provide oral or written anticipatory guidance to the parent or guardian of a child starting at 6 months of age and continuing until 72 months of age that includes, at a minimum, the information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age.

B. Providers must order or perform blood lead level screening tests on all child Members in accordance with the following:

1. At 12 months and at 24 months of age;
2. When the Provider performing a PHA becomes aware that a Member who is 12 to 24 months of age has no documented evidence of a blood lead screening test taken at 12 months of age or thereafter;
3. When the Provider performing a PHA becomes aware that a Member who is 24 to 72 months of age has no documented evidence of a blood lead screening test taken;
4. At any time a change in circumstances has, in the professional judgement of the Provider, placed the child Member at risk of lead poisoning; or
5. If requested by the parent or guardian.

C. All blood lead level screenings, confirmatory and follow-up testing must be performed and interpreted in accordance with CLPPB guidelines. Providers must follow the Centers for Disease Control and Prevention (CDC) requirements for Post-Arrival Lead Screening of Refugees contained in CLPPB issued guidelines (https://www.cdc.gov/immigrantrefugeehealth/).

D. Providers are not required to perform a blood lead screening test if either of the following applies:

1. The parent, guardian, or other person with legal authority to withhold consent for the child refuses to consent to screening; and/or
2. In the Provider's professional judgement, the screening poses a greater risk to the child's health than the risk of lead poisoning.

E. Providers must document refusals or reasons for not performing the blood lead screening in the child's medical record.[7]

1. In cases where consent has been withheld, Providers must obtain a signed statement of

[7] Ibid.

voluntary refusal to document in the child Member's medical record.

2. If the Provider is unable to obtain a signed statement of voluntary refusal because the party that withheld consent either refused or declined to sign a statement of voluntary refusal, or is unable to sign a statement of voluntary refusal (e.g. when services are provided via telehealth modality), the Provider must document the reason for not obtaining a signed statement of voluntary refusal in the child member's medical record.

F. Providers must follow the CLPPB guidelines when conducting blood lead screening tests, interpreting blood lead levels, and determining appropriate follow-up activities.[8]

G. IEHP will monitor compliance with CLPPB guidelines for blood lead screening tests through the Facility Site Review and Medicare Record Review process.

H. IEHP informs its Providers, through the secure online IEHP Provider portal, of all child Members between the ages of six months to six years (i.e. 72 months), who have no record of receiving a blood lead screening test. IEHP identifies the age at which the required blood lead screenings were missed, including children without any record of a completed blood lead screening at each age. Providers are expected to test these child Members and provide the required written or oral anticipatory guidance to the parent/guardian of these child Members.[9]

Adverse Childhood Experience (ACE) Screening

A. ACE screenings in all inpatient and outpatient settings are only reimbursable for contracted Providers who complete the certified core ACEs Aware online training and who self-attest that they have completed this training; and have used the Pediatric ACEs Screening and Related Life-events Screener (PEARLS), which can be found in various languages at https://www.acesaware.org/learn-about-screening/screening-tools/screening-tools-additional-languages/.

B. The Provider must maintain the following documentation in the Member's medical record, and make these available to IEHP, upon request:

1. The screening tool that was used;
2. That the completed screen was reviewed;
3. The results of the screen;
4. The interpretation of results; and
5. What was discussed with the Member and/or family, and any appropriate actions taken.

Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)

A. SABIRT services may be provided by Providers in primary care setting and within their scope

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[8] Ibid.

[9] Title 17 California Code of Regulations (CCR) § 37100

of practice, including, but not limited to, physicians, physician assistants, nurse practitioners, certified nurse midwives, licensed midwives, licensed clinical social workers, licensed professional clinical counselors, psychologists and licensed marriage and family therapists. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.

B. PCPs, within their scope of practice, must provide SABIRT services for Members 11 years of age and older, including pregnant women as follows:

1. When the Member responds affirmatively to the alcohol pre-screen question on the SHA, the PCP must conduct screening for unhealth alcohol and drug use using validated screening tools, including but not limited to:

   a. Alcohol Use Disorders Identification Test (AUDIT-C). See "Attachment/AUDIT-C" found on the IEHP website;[10]

   b. Brief Addiction Monitor (BAM). See "Attachment/Brief Addiction Monitor (BAM) With Scoring & Clinical Guidelines" found on the IEHP website;[11]

   c. Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID);

   d. Tobacco Alcohol, Prescription Medications and other Substances (TAPS);

   e. National Institute on Drug Abuse (NIDA) Quick Screen for Adults (The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening);

   f. Drug Abuse Screening Test (DAST-10);

   g. Parents, Partner, Past and Present (4Ps) for adolescents; and

   h. Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents.

   Please see Policy 10B, "Adult Preventive Services" for a list of validated tools for adults and pregnant women.

2. When the Member's screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or substance use disorder is present. Validated alcohol and drug assessment tools include, but are not limited to:

   a. Alcohol Use Disorders Identification Test (AUDIT);

   b. Brief Addiction Monitor (BAM). See "Attachment/Brief Addiction Monitor (BAM) With Scoring & Clinical Guidelines" found on the IEHP website;[12]

   c. NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test

[10] https://www.iehp.org/en/providers/provider-resources?target=forms
[11] Ibid.
[12] Ibid.

(NM-ASSIST); and

d. Drug Abuse Screening Test (DAST-20).

3. The PCP must offer immediate brief misuse counseling when a Member reveals unhealthy alcohol use. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to Members whose brief assessment demonstrates possible alcohol use disorder (AUD) or substance use disorder (SUD). Brief interventions must include the following:[13]

   a. Providing feedback to the Member regarding screening and assessment results;

   b. Discussing negative consequences that have occurred and overall severity of the problem;

   c. Supporting the Member in making behavioral changes; and

   d. Discussing and agreeing on plans for follow-up with the Member, including referral to other treatment if indicated.

4. The PCP must ensure the Member's medical record include the following:

   a. The service provided (e.g., screen and brief intervention);

   b. The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record);

   c. The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record); and

   d. If and where a referral to an AUD or SUD program was made.

5. IEHP will make good faith efforts to confirm whether Members receive referred treatments and document when, where, and any next steps following treatment. If a Member does not receive referred treatments, IEHP will follow up with the Member to understand barriers and make adjustments to the referrals as needed. IEHP may also attempt to connect with the Provider to whom the Member was referred to facilitate a warm hand-off to necessary treatment.

C. IEHP informs Members of SABIRT services through Member-informing materials, including but not limited to the Evidence of Coverage (EOC).

D. When a Member transfers from one PCP to another, the receiving PCP must attempt to obtain the Member's prior medical records, including those pertaining to the provision of preventive services.

E. IEHP complies with all applicable laws and regulations relating to the privacy of substance

[13] Ibid.

use disorder records, as well as state law concerning the right of minors over 12 years of age to consent to treatment.[14,15] See Policies 3B, "Information Disclosure and Confidentiality of Medical Records" for information on confidentiality of medical records, and Policy 4E, "Access to Services with Special Arrangements" for more information on minor consent services.

Tobacco Prevention and Cessation

A. PCPs are required to provide interventions, including education or counseling, to prevent initiation of tobacco use in school-aged children and adolescents. Additionally, since secondhand smoke can be harmful to children, counseling parents who smoke, in a pediatric setting, is also recommended. Coverage of medically necessary tobacco cessation services, including counseling and pharmacotherapy, is mandatory for children up to the age of 21.

B. With regards to Members identified as using tobacco products, IEHP encourages Providers to implement the following interventional approach:

   1. Providers are encouraged to use a validated behavior change model to counsel Members who use tobacco products. Training materials for the following examples may be requested from IEHP by calling the Providers Relations Team at (909) 890-2054 or accessed online through the IEHP website at www.iehp.org:

      a. Use of the "5 A's" – Ask, Advise, Assess, Assist, and Arrange; and

      b. Use of the "5 R's" – Relevance, Risks, Rewards, Roadblocks, and Repetition.

   2. Members are able to receive a minimum of four (4) counseling sessions of at least 10 minutes per session. Members may choose individual or group counseling conducted in person or by telephone.

      a. Individual, group, and telephone counseling is offered at no cost to Members who wish to quit smoking, whether those Members opt to use tobacco cessation medications.

   2. Two (2) quit attempts per year are covered without prior authorization and there are no mandatory breaks between quit attempts.

      a. The lists of appropriate Current Procedure Terminology (CPT) and International Classification of Diseases (ICD) codes for tobacco use may be accessed online through the IEHP non-secure Provider portal at www.iehp.org.

   3. Members are to be referred to the California Smoker's Helpline (1-800-NO-BUTTS) or other comparable quit-line service. Providers are encouraged to use the Helpline's web referral, or if available in their area, the Helpline's e-referral system.

Cholesterol Screening

[14] 42 CFR §§ 2.1 & 2.14 et. seq
[15] California Family Code § 6929

A. PCPs must perform cholesterol screening on children ages 2-21 years with risk factors and conduct universal screening at ages 9-11 and 17-21 years. Physicians can use a non-HDL cholesterol test that does not require children to fast, and children with abnormal results should be followed up with a fasting lipid profile.

Diabetes Screening

A. PCPs must screen for type 2 diabetes and pre-diabetes beginning at age 10 years or onset of puberty and test every three (3) years using A1C with children who are overweight with two (2) or more risk factors (American Diabetes Association).

Dental Screening

A. Dental screening/oral health assessment is included as part of the IHA and then periodically thereafter according to the Dental Periodicity Schedule. See "Attachment/Periodicity Schedule – Dental" found on the IEHP website.[16] For more information about the initial health assessment, See Policy 5A, "Initial Health Assessment." Dental Assessments must include documentation in the medical record about the condition/findings of the mouth, teeth and gums.

B. Dental caries prevention – Prescribe oral fluoride supplementation starting at age 6 months through age 16 years for children where water supply is deficient in fluoride.

C. Dental caries prevention – Apply fluoride varnish to primary teeth of infant and children starting at the age of primary tooth eruption and repeat every three (3) to six (6) months.

D. PCPs are required to refer children to a dentist annually, starting with the eruption of the children's first tooth or at 12 months of age. A referral may be made earlier or more frequently if dental problems are suspected or detected.

Tuberculosis Screening

A. PCPs are mandated to follow the latest Centers for Disease Control and Prevention (CDC) Guidelines for TB control as part of the health assessment. For guidance and list of laboratory test options, please see the CDC web page at www.cdc.gov.

Member Notification

A. IEHP notifies Members of the availability of health assessment services upon enrollment through the Post-Enrollment Kit and Benefits Sheet. Ongoing notification takes place through the Member Newsletter and IEHP staff contact, as appropriate.

B. At each non-emergency primary care encounter with a Member under the age of 21 years, PCPs are required to advise the Member, and/or parent(s) or guardian of the Member, of the pediatric preventive services available, and give information on how to access the services.

[16] https://www.iehp.org/en/providers/provider-resources?target=forms

C. Written notification and an explanation of the results of health assessments must be supplied to the Member, or the parent(s) or guardian of the minor Member. The PCP must also provide discussion or consultation regarding the results of the assessment, if appropriate, or if requested by the Member, or the parent(s) or guardian.

D. In a situation where a Member has been scheduled for or has begun the health assessment process, and then disenrolls, or becomes ineligible with IEHP prior to the completion of screening and related diagnostic and treatment services, the PCP may continue to provide care through the CHDP 200% program, if the PCP is certified by the County CHDP Program. If the PCP is not an approved CHDP Practitioner, the Member must be referred to the Local Health Department CHDP Program, to receive assistance in accessing a certified CHDP Practitioner. IEHP Member Services maintains current lists of certified CHDP Practitioners in the counties and helps facilitate the referral process as needed.

E. The cumulative health record for each Member must contain:

1. Screening services provided, and results thereof;
2. Referral for diagnosis and treatment;
3. Results of diagnosis and treatment services;
4. Outreach and follow-up activities to assure that Members have received needed services; and
5. Notation of acceptance or refusal of services by Member, parent(s), or guardian.

Reporting

A. Appropriate CPT codes must be used when reporting claim and encounter data. See Policy 14A, "Encounter Data Submission Requirements for Directly Capitation Providers."

B. Blood Lead Screening Test Results

1. Providers must report all blood lead screening results electronically to the CLPPB. Laboratories performing blood lead analysis on blood specimens drawn in California must electronically report all results to CLPPB. Reporting must include specified patient demographic information, the ordering physician, and analysis data on each test performed.
2. IEHP will maintain records, for a period of no less than 10 years, of all child Members identified quarterly as having no record of receiving a required blood lead screening test.
3. IEHP will utilize CMS-1500/UB-04 claim forms, or their electronic equivalents (837-P/837-I), to report confidential screening/billing.
4. IEHP will educate Providers, including laboratories, about appropriate CPT coding to ensure accurate reporting of all blood lead screening tests, and submit complete, accurate, reasonable, and timely encounter data.

5. IEHP will ensure blood lead screening encounters are identified using the appropriate indicators.

Provider Education

A. IEHP does not require CHDP certification; however, all PCPs must provide pediatric preventive services according to Bright Futures/AAP standards, and all PCPs must be trained on Bright Futures/AAP guidelines.

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5. MEDICAL CARE STANDARDS

C. Pediatric Preventive Services

2. Immunization Services

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. IEHP ensures that all children receive necessary immunizations timely according to the most recent U.S. Public Health Service's Advisory Committee on Immunization Practice (ACIP) recommendations.[1,2,3] See "Attachment/Recommended and Catch-Up Childhood Immunization Schedules" found on the IEHP website.[4]

PROCEDURES:

A. IEHP provides all Primary Care Providers (PCPs) with updated copies of the immunization schedules as they become available from the Centers for Disease Control and Prevention (CDC).

B. PCPs are mandated to provide immunizations as part of the IEHP Well Child program in conjunction with periodic well child assessments. In addition, other types of visits (acute or follow-up) should be utilized to immunize children that are behind schedule. See Policy 10C1, "Pediatric Preventive Services – Well Child Visits" for more information.

C. IEHP contracts define immunization services as a Plan responsibility. Immunizations are preventive services, however they are still subject to prior authorization requirements.

D. If a PCP receives information from the Local Health Department (LHD), an immunization registry, other health Provider, or the Member (parent), that adequately documents that immunization(s) has been received by the Member, the PCP is responsible for documenting the received immunization(s) in the medical record and for assessing the need and timing of any additional immunization appropriate for the Member. See Policy 7A, "Provider Medical Record Requirements" for more information.

E. Vaccines for Children – All PCPs with Members assigned ages 0-19 must enroll in the VFC program. VFC is a federally funded and state-operated program that supplies practitioners with vaccine for administration to children who meet eligibility requirements. For more information on VFC call (877) 243-8832.

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[1] https://www.cdc.gov/vaccines/hcp/acip-recs/index.html
[2] California Health and Safety Code (Health & Saf. Code) §1300.67
[3] CA Health & Saf. Code 1367.3
[4] https://www.iehp.org/en/providers/provider-resources?target=forms

F. Access:

1. To maximize the provision of immunizations, all Members should access immunization services through their assigned PCP.

2. Members can also access immunization services through LHD immunization clinics. When a Member accesses an LHD clinic for immunizations, the LHDs should support non-duplication of immunization services. The LHD clinic utilizes the California Immunization Registry (CAIR2), the Member's California Immunization Record, or contacts the Member's PCP, to determine the immunization status of the Member. Members needing follow-up care are referred to their PCP by the LHD.

G. Recording and Tracking Member Immunizations

1. Providers must document each Member's need for ACIP-recommended immunizations as part of all regular health visits including, but not limited to, the following encounter types:
   a. Illness, care management, or follow-up appointments;
   b. Initial Health Assessments (IHAs);
   c. Pharmacy services;
   d. Prenatal and postpartum care;
   e. Pre-travel visits;
   f. Sports, school, or work physicals;
   g. Visits to a LHD; and
   h. Well patient checkups.

2. Practitioners must maintain a system to record and track Member immunizations, which includes the following elements:
   a. A record of immunizations must be maintained in each Member's medical record.
   b. Practitioners or Providers must review each medical record before a Member's appointment to determine any needed immunizations, which are then administered as appropriate during the appointment.
   c. Members must be asked their immunization history and whether they have recently received any immunizations from out-of-network practitioners. If any recent immunizations are identified, the PCP verifies the immunization by looking up the Member in the Immunization Registry, or by confirming the Member's immunization history through the IEHP Provider website. The information must then be entered into the Member's medical record.

3. Whenever a vaccine is administered, it must be documented in the Member's medical record. For each immunization administered, documentation must include the type of immunization, series, lot number, manufacturer, expiration date, injection site and initials of the person administering the immunization.

   a. Providers must report Member-specific immunization information to the immunization registry that is part of the Statewide Immunization Information System (e.g. CAIR2). Reports must be made after a Member's IHA and after all healthcare visits that result in an immunization. IEHP strongly recommends immunizations are reported within 14 days of administration.

   b. Participating Providers can enter and access all relevant immunization data for any child tracked by the system, including children receiving immunizations at different sites. Providers interested in participating and enrolling in the program should call CAIR Help Desk at 1-800-578-7889. Further information and web access are also available online at www.cairweb.org.

4. Documentation should also be completed by the Provider when vaccines are declined or deferred by the Member. This documentation should include:

   a. Documented attempts that demonstrate the Provider's unsuccessful efforts to provide the immunization;

   b. If immunizations cannot be given at the time of the visit, the Member must be instructed as to how to obtain necessary immunizations or a scheduled and documented appointment must be made; and

   c. Proof of voluntary refusal of vaccines in the form of a signed statement by the Member (if an emancipated minor) or the Parent(s) or guardian of the Member. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's medical record.

5. Practitioners must provide Members documentation of their immunizations if requested by the Member. This may be provided via the California Immunization Record.

6. Follow-up must be documented for missed appointments. See Policy 4B, "Missed Appointments."

H. Reimbursement of LHDs for Immunizations administered to IEHP Covered Members only:

1. LHD clinics must be reimbursed an administration fee, at current Medi-Cal rates, for immunization services provided, excluding immunizations for which the Members is already up-to-date.

2. Conditions for Reimbursement:

   a. The LHD must submit claims to the Member's assigned Plan on CMS-1500 billing forms, using the appropriate CPT and ICD codes.

b. The LHD must provide immunization records. If a Member refuses the release of medical information, the LHD must submit documentation of such a refusal.

c. Claims from LHD for immunization services that were misdirected to IEHP will be returned to the LHD for resubmission to the appropriate Plan.

3. Vaccine Reimbursement Process for Providers not enrolled in the Vaccines for Children (VFC) Program is as follows:

a. Providers must complete the CMS-1500 by including the appropriate CPT codes, quantity dispensed and billed amount.

b. Claims are to be submitted to:

IEHP Claims Department
P.O. Box 4349
Rancho Cucamonga, CA 91729-4349

c. IEHP will not reimburse Providers for vaccine serum for Members ages 0-19 who should receive vaccine serum supplied by the Vaccines for Children (VFC) program.

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5. MEDICAL CARE STANDARDS

D. Obstetrical Services

1. Guidelines for Obstetrical Services

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. All Providers of obstetrical (OB) services are required to follow the most current edition of the American Congress of Obstetricians and Gynecologists' (ACOG) Guidelines for Perinatal Care, as the minimum standard of care.[1] When applicable, Providers are required to also follow Grade A and B recommendations from the U.S. Preventive Services Task Force (USPSTF).[2]

B. In addition to medical OB services, OB Practitioners provide all Medi-Cal Members with perinatal support services, including an initial comprehensive risk assessment, reassessments, and interventions as determined by risk. Participation in support services is voluntary and Members have the right to refuse any services offered.

PROCEDURES:

Identification of Pregnant Members

A. IEHP identifies Members who are pregnant through claims data, encounter data, pharmacy, data, laboratory results, data collected through the utilization management or care management processes, authorizations, and referrals.

B. Providers are also responsible for assessing whether a Member is pregnant, including the provision of pregnancy testing as appropriate.

Access to Perinatal Services

A. Once the Primary Care Provider (PCP) or any other Specialist has established that the Member is pregnant, the Member may receive assistance from the PCP, their assigned Plan, or IEHP in scheduling an appointment for perinatal care.

B. IEHP must allow Members direct access, without referral, to a participating Provider that meets IEHP credentialing standards to provide OB/GYN services.[3,4] Basic perinatal services include the initiation of prenatal care visits, initial comprehensive risk assessment, all subsequent risk assessments by trimester, and low risk interventions conducted in the OB Specialist's office.

[1] American Congress of Obstetrician and Gynecologists (ACOG), Guidelines for Perinatal Care, https://www.acog.org/clinical.
[2] USPSTF Grade A and B Recommendations, https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
[3] California Health and Safety Code (Health & Saf. Code) § 1367.695(b)
[4] NCQA, 2024 HP Standards and Guidelines, MED 1, Element A

C. Referrals for high-risk OB conditions, health education, nutrition, or psychosocial services are processed through the Plan's standard authorization process. Determinations must be made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Practitioners.[5,6] See Policy 9D, "Pre-Service Referral Authorization Process" for more information.

D. The initial prenatal visit must be scheduled to take place within two (2) weeks of the request. Urgent prenatal visits must be scheduled to take place within forty-eight (48) hours of the request.[7] Prenatal care should be initiated within the first trimester whenever possible.

E. Pregnant Members may receive perinatal care services from Certified Nurse Midwives (CNMs), Licensed Midwives (LMs) or Alternative Birthing Centers (ABCs) within or outside the Member's Plan or IEHP's network. See Policy 5D2, "Obstetrical Services – Obstetric Care by Certified Nurse Midwives."

Multidisciplinary Perinatal Services

A. IEHP Members who are pregnant receive perinatal support services in addition to medical obstetrical (OB) care and maternal mental health. Support services are in the areas of nutrition, health education, and psychosocial issues, and are provided by a variety of multi-disciplinary staff, as appropriate.

B. Basic perinatal support services are generally provided by one of the multi-disciplinary staff members in the perinatal Practitioner's office. Examples of staff that can provide basic services include:

1. MD or DO;
2. Nurse Practitioner;
3. Certified Nurse Midwife;
4. Licensed Midwife;
5. Registered Nurse;
6. Licensed Vocational Nurse;
7. Medical Assistant;
8. Social Worker;
9. Health Educator; or
10. Health Care Worker.

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[5] Title 42 Code of Federal Regulations (CFR) §§ 438.210, 422.568, 422.570, and 422.572
[6] https://www.iehp.org/en/providers/provider-resources?target=forms
[7] Title 28, California Code of Regulations (CCR) § 1300.67.2.2(c)(5)(A)

C. Perinatal support services for Members with high-risk conditions might be provided outside the perinatal Practitioner's office by licensed professionals including:

1. Registered Dietitian;
2. Health Educator with Master's level degree;
3. Psychiatrist;
4. Psychologist; or
5. Marriage, Family, and Child Counselor (MFCC) or Licensed Clinical Social Worker (LCSW).

Perinatal Care

A. The content and timing of perinatal care should be varied according to the needs and risk status of the Member and their fetus. Typically, a Member with an uncomplicated first pregnancy is examined every four (4) weeks for the first 28 weeks of pregnancy, every two (2) weeks until 36 weeks of gestation, and weekly thereafter. Members with active medical or OB problems, as well as Members at the extremes of reproductive age, should be seen more frequently, at intervals determined by the nature and severity of the problems. [8]

B. During episodic or focused health care visits of Members who could become pregnant, in addition to performing a physical exam and obtaining her obstetric and gynecologic histories, the following core topics in pre-pregnancy should be addressed:[9]

1. Family planning and pregnancy spacing. See Policy 5F, "Family Planning Services";
2. Immunization status. See Policy 5B, "Adult Preventive Services";
3. Risk factors for sexually transmitted infections. See Policy 5G, "Sexually Transmitted Infection Services";
4. Substance use, including alcohol, tobacco, and recreational and illicit drugs;
5. Exposure to violence and intimate partner violence;
6. Medical, surgical, and psychiatric histories;
7. Current medications;
8. Family history;
9. Genetic history;
10. Nutrition, body weight, and exercise;
11. Teratogens, environmental and occupational exposures; and

[8] ACOG, Guidelines for Perinatal Care, https://www.acog.org/clinical
[9] Ibid.

12. Assessment of socioeconomic, education, and cultural context

C. Risk assessments must be performed during the initial prenatal visit, once each trimester thereafter and at the post-partum visit. Results from these assessments shall be maintained as part of the obstetrical record and include medical, obstetrical, nutritional, psychosocial, and health education needs risk assessment components. See "Attachments/ACOG Antepartum Record," "Initial Perinatal Risk Assessment Form – English," "Initial Perinatal Risk Assessment Form – Spanish," "Combined 2nd Trimester Reassessment," "Combined 3rd Trimester Reassessment," and "Combined Post-Partum Assessment" found on the IEHP website.[10,11,12] If a Member refuses any or all risk assessments, a note documenting the attempt and refusal must be noted in the medical record.

D. The OB Practitioner must develop an individualized plan of care that is based on ongoing risk identification and assessment, as well as take into consideration the medical, nutritional, psychosocial, cultural, and educational needs of the Member. This plan of care must include obstetrical, nutrition, psychosocial, and health education interventions, and be periodically re-evaluated and revised in accordance with the progress of the pregnancy.[13,14]

E. All Members must receive a prescription for prenatal vitamins as a standard of care.[15]

F. Dental screening is considered a part of routine prenatal care and is also available through the PCP. The PCP is responsible for screening Members for dental and oral health and making referral for treatment as appropriate. Referral for dental care does not require prior authorization by the Plan, and Members may self-refer to Medi-Cal dental practitioners. IEHP Member Services assists both PCPs and Members in locating dental Practitioners by supplying the access number to the Medi-Cal dental referral line.

Tobacco Prevention and Cessation

A. The USPSTF recommends that clinicians ask all pregnant people about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant people who use tobacco (Grade A recommendation). Because of the serious risk of smoking to the pregnant smoker and fetus, whenever possible, Members should be offered tailored, one-on-one counseling exceeding minimal advice to quit, as described below.

   1. Individual, group, and telephone counseling is offered at no cost to Members who wish to quit smoking, whether or not those Members opt to use tobacco cessation medications.

[10] 22 CCR § 51348(b)(1)
[11] Click here for the most current forms: https://www.acog.org/clinical-information/obstetric-patient-record-forms
[12] https://www.iehp.org/en/providers/provider-resources?target=forms
[13] ACOG, Guidelines for Perinatal Care, https://www.acog.org/clinical
[14] 22 CCR § 51348(b)(2)
[15] 22 CCR § 51348(c)(3)

2. Providers are required to ask all pregnant Members if they use tobacco or are exposed to tobacco smoke at every doctor visit. Pregnant Members who smoke should obtain assistance with quitting throughout their pregnancies.

3. ACOG recommends clinical interventions and strategies for pregnant Members who use tobacco.[16]

4. Providers are to offer at least one (1) face-to-face tobacco cessation counseling session per quit attempt. Face-to-face tobacco cessation counseling services may be provided by, or under supervision of, a physician legally authorized to furnish such services under state law. Tobacco cessation counseling services are covered for 60 days after delivery, plus any additional days needed to end the respective month.

5. Two (2) quit attempts per year are covered without prior authorization and there are no mandatory breaks between quit attempts.

   a. Current Procedure Terminology (CPT) and International Classification of Diseases (ICD) codes for tobacco use are available on the Provider Training Guide, which can be requested through Providers Services or available online on the Provider Portal.

6. Providers are to ensure pregnant Members who use tobacco are referred to the California Smoker's Helpline (1-800-NO-BUTTS) or other comparable quit-line service. Providers are encouraged to use the Helpline's web referral, or if available in their area, the Helpline's e-referral system.

Genetic Screening

A. Information about the California Prenatal Screening Program must be offered to Members seen prior to the 20th week of pregnancy.

   1. The current services provided by the California Prenatal Screening Program may be found on the program's website: https://www.cdph.ca.gov/Programs/CFH/DGDS/pages/pns.

   2. Abnormal screening results are then followed up by State-approved diagnosis centers. (See Attachment, "California Prenatal Screening Program" found in the IEHP website).[17] Further diagnostic investigations must be coordinated by the prenatal care Provider as indicated.

B. Antenatal screening must be done whenever indicated to identify possible risks prior to pregnancy. Parents who have increased risks for pregnancies complicated by genetic abnormalities are referred to State-approved Prenatal Diagnosis Centers for appropriate counseling. For the most current listing of State-approved Prenatal Diagnosis Center by County, go to http://cdph.ca.gov or call the Genetic Disease Branch, California Department

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[16] The American Congress of Obstetricians and Gynecologists, "Committee Opinion Smoking Cessation During Pregnancy," Number 721, October 2017

[17] https://www.iehp.org/en/providers/provider-resources?target=forms

of Health Care Services at (866) 718-7915.[18]

High Risk Obstetrical Care

A. Pregnant Members at high-risk of a poor pregnancy outcome must be referred to appropriate Specialists including perinatologists and with proper referrals, have access to genetic screening.

Intrapartum Care

A. As a part of their prenatal care and counseling, all Members must be informed of the Hospital/birth facility where they are going to deliver. Members are assigned to a Hospital/birth facility based on their PCP's affiliation. An OB Practitioner must be able to deliver a Member at her assigned Hospital/birth facility. Members must be reminded that they are to deliver at their assigned Hospital/birth facility, unless they are directed to deliver at an advanced OB or neonatal center.

B. OB Practitioners must forward the Member's medical records to the delivery Hospital/birth facility no later than four (4) weeks prior to the anticipated delivery date. Members must receive instructions on what to do in case of emergency or pre-term labor.

Postpartum Care

A. As the primary Practitioner of care during pregnancy, the OB Practitioner is responsible for identifying the newborn's Physician on the antepartum record. In addition, the OB Practitioner, in conjunction with the Plan and Hospital/birth facility, coordinates referral of the newborn to the PCP within the mother's Plan network for inpatient newborn care and continuing outpatient care. In the event the Member presents without an elected Physician, the Hospital is to contact the Plan's admitter panel for initial assessment of the newborn.

B. Newborns must also be screened and referred for genetic disorder evaluation as appropriate.

C. The OB Practitioner is responsible for coordinating the care of the Member back to the PCP after the postpartum evaluation is completed.

D. All Members should undergo a comprehensive postpartum visit within the first six (6) weeks after birth. This visit should include a full assessment of physical, social, and emotional well-being. The postpartum visit includes but is not limited to educating the Member on family planning, immunization, and referrals to a pediatric Practitioner for Well Child services and the Supplemental Food Program for Women, Infants and Children (WIC). See Policies 5C1, "Pediatric Preventive Services – Well Child Visits," 5C2, "Pediatric Preventive Services – Immunization Services," 10E, "Referrals to the Supplemental Food Program for Women, Infants, and Children," and 05F, "Family Planning Services."

[18] https://www.cdph.ca.gov/Programs/CFH/DGDS/CDPH%20Document%20Library/PNS%20Documents/PDCs_by_County.pdf

IEHP Responsibilities

A. IEHP informs Members of childbearing age of the availability of perinatal services, and how to access services through the Member Handbook, Member Newsletter, Member Services contacts, and Health Education programs. Members may also contact IEHP Member Services Department at (800) 440-4347 for information on perinatal services.

B. IEHP ensure that upon their request, current or newly enrolled Members with specified conditions can continue to obtain health care services from a Provider ending their contract with their Plan. This includes Members in the 2nd or 3rd trimesters of pregnancy and the immediate postpartum period, and newborn children between birth and age 36 months.[19] See Policy 7A2, "Care Management Requirements – Continuity of Care" for more information.

C. IEHP is responsible for coordinating referrals needed by the high-risk Member including but not limited to: education and lifestyle change for gestational diabetics, perinatology, neonatologists or advanced OB and neonatal centers, transportation and durable medical equipment, as appropriate.

D. The Member's Plan Case Management staff are responsible for assuring the coordination of all multi-disciplinary practitioners providing interventions for pregnant Members through transfer of medical records or intervention details, facilitation of necessary referrals and case conferences if necessary.

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[19] CA Health & Saf. Code § 1373.96

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. Pregnant Members may receive perinatal care services from Certified Nurse Midwives (CNMs), Licensed Midwives (LMs) or Alternative Birthing Centers (ABCs) within or outside the Member's Plan or IEHP's network.

DEFINITIONS:

A. Alternative Birthing Center (ABC) – A health facility that is not a hospital and is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan.

PROCEDURES:

A. IEHP must allow women direct access, without referral, to a participating Provider that meets IEHP credentialing standards to provide OB/GYN services.[1, 2]

B. Once pregnancy has been established by the Primary Care Provider (PCP) or another Provider, Members may access prenatal care from an Obstetrician, CNM, LM, or other qualified prenatal care Practitioner within or outside the Member's Plan network.

C. CNM and LM services are limited to the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period.[3]

D. CNMs and LMs must have Physician back up with an IEHP network Obstetrical Practitioner credentialed by the Plan or IEHP for consultation, high-risk referral, and delivery services, as needed.

E. Out-of-network CNMs and ABCs must be reimbursed no less than the Medi-Cal Fee-for-Services (FFS) rate for services provided if IEHP or the Member's assigned Plan is unable to provide access to in-network CNMs or ABCs.

F. IEHP informs Members of their right to obtain services from out-of-network CNMs, LMs and ABCs, when access to these provider types is not available in-work. Members are informed through the IEHP Medi-Cal Member Handbook and during telephonic encounters.

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[1] California Health and Safety Code (Health & Saf. Code) § 1367.695(b)
[2] National Committee for Quality Assurance (NCQA), 2024 Health Plan (HP) Standards and Guidelines, MED 1, Element A
[3] Title 22, California Code of Regulations (CCR) § 51345

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5. MEDICAL CARE STANDARDS

D. Obstetrical Services

3. PCP Provision of Obstetric Care

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. Primary Care Providers (PCPs) providing obstetrical (OB) care must meet the criteria established by IEHP, for participation in the network as an Obstetrics Provider, as set forth below.

PROCEDURES:

A. All PCP listed as a Family Practice 1 (FP1), Family Practice 2 (FP2), and Obstetrics and Gynecology, providing OB services to Members must meet the following criteria:

   1. Education & Training. All practitioners must meet the education and training requirements for one (1) of the following specialties, set for forth by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA).

      a. Family Practice, also applicable to:

         1) Family Practice 1: Family Practice Providers with OB Services

         2) Family Practice 2: Family Practice Providers that includes OB services and delivery

      b. Obstetrics and Gynecology

   2. Hospital privileges. The Practitioner must have admitting privileges that include delivery, at an IEHP participating Hospital. For those Practitioners who do not hold their own admitting privileges that includes delivery, the following documentation must be provided for review:

      a. Family Practice 1 Providers must provide a signed agreement that states Member transfers will take place within the first 28 weeks of gestation and a protocol for identifying and transferring high risk Members with a contracted and credentialed OB.

         1) The OB must be within the same network as the Family Practice Provider and hold admitting privileges to the IEHP contracted Hospital linked with that network.

      b. Family Practice 2 Providers must hold admitting privileges with delivery, at an IEHP participating Hospital and provide a written agreement for an available OB back up Provider is required.

1) The OB must be credentialed, contracted and hold admitting privileges to the IEHP Hospital linked with the Family Practice Provider; and
2) Provide a protocol for identifying and transferring high risk Members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc.).

c. Obstetrics/Gynecology (OB/GYN) Providers who would like to participate as a PCP, will provide outpatient well woman services only with no Hospital or Surgical privileges, must provide the following information for consideration:

1) In lieu of having full Hospital delivery privileges, provide a written agreement with an OB Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.), must be available for consultations, as needed and that the OB will provide prenatal care after twenty-eight (28) weeks gestation including delivery. See "Attachment/Patient Transfer Agreement" found on the IEHP website.[1]
   - The Agreement must include back-up Physician's full delivery privileges at IEHP network Hospital, in the same network as the non-admitting OB Provider.
   - The OB Provider within the same practice and must be credentialed and contracted within the same network.
2) These OB/GYNs provide outpatient well woman services only with no Hospital or surgical privileges. This exception must be reviewed and approved by IEHP Chief Medical Officer (CMO) or IEHP Medical Director designated by the CMO. Further review may be completed by the Credentialing or Peer Review Subcommittee.[2]

3. Facility Site Review. After submission of a request through an application for IEHP's Direct Network or Provider Profile from the Plan, IEHP staff schedules a site visit to determine if all facility criteria are met.

a. All PCPs must pass a required initial facility site review performed by IEHP prior to receiving IEHP enrollment and treating members.

b. IEHP provides written notice to requesting Practitioners after the site visit either approving them under, or not approving them with the reasons noted.

1) PCPs denied participation due to quality of care can submit a written appeal to the IEHP Chief Medical Officer within 30 days of the notification of the

[1] https://www.providerservices.iehp.org/en/resources/provider-resources/forms
[2] California Health & Safety Code § 1367.69

decision. See “Attachment/IEHP Peer Review Level I and Credentialing Appeal” found on the IEHP website.[3]

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[3] https://www.providerservices.iehp.org/en/resources/provider-resources/forms

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. IEHP Covered Members may obtain sterilization services (tubal ligation or vasectomy) at any qualified family planning Practitioner in or out of the Plan's IEHP network.

B. IEHP ensures that obtaining and documenting informed consent for services, including sterilization, comply with State, Federal and contractual requirements.[1] See Policy 3C, "Informed Consent."

PROCEDURES:

A. According to IEHP's Division of Financial Responsibility (DOFR), professional services associated with sterilization are the Plan's responsibility. This responsibility includes payment of services accessed by the Medi-Cal Member at any qualified family planning Practitioner. IEHP is responsible for the facility charges resulting from qualifying inpatient sterilization services.

B. Access to Sterilization Services

   1. The Medi-Cal Member selects a qualified family planning Practitioner of their choice within the IEHP network, or out-of-network. Member Services refers Members to the State Office of Family Planning at (916) 650-0414 to receive more information on qualified family planning Practitioners.

   2. Out-of-network family planning Practitioners are expected to demonstrate a reasonable effort in coordinating services with IEHP network Practitioners, including educating Members to return to their PCP for continuity and quality of care.

   3. Contracted and out-of-network family planning Practitioners must be reimbursed for covered family planning services when the following conditions are met:

      a. The family planning Practitioner must submit claims for sterilization services to the Member's Plan or IEHP Claims Department on a CMS 1500 form, using the appropriate CPT and ICD codes. PM 330 Sterilization Consent Form must be included with the claim.

      b. The family planning Practitioner must provide proof of service. If a Member refuses the release of medical information, the out-of-network Practitioner must submit

[1] Title 22, California Code of Regulations (CCR) § 51305.1 et seq.

documentation of such a refusal.

B. Informed Consent

1. The Member must be at least 21 years of age at the time consent for sterilization is obtained, mentally competent to understand the nature of the proposed procedure and cannot be institutionalized.[2]

2. The PM 330 Sterilization Consent Form, which contains federal funding language, must be used, as mandated by the State of California. See "Attachments/PM 330 Sterilization Consent Form – English" and "PM 330 Sterilization Consent Form – Spanish" found in the IEHP website.[3,4]

   a. One (1) copy of the State of California approved booklets must be furnished to the Member, along with the consent forms.[5]

   b. The Practitioner must have a discussion with the Member after the Member has read the booklet. This discussion must be noted in the progress notes of the Member's medical record.

      1) The PM 330 Sterilization Consent Form must be signed by the Member after the discussion has taken place.[6] If an interpreter is used, he/she must also sign the consent form verifying his/her part in the discussion.[7] Suitable arrangements must be made to ensure that all necessary information is relayed to a Member who is visually impaired, deaf or otherwise a person with a disability.

      2) Informed consent may not be obtained while the Member is under the influence of alcohol, or any substance that affects the Member's state of awareness. Consent may not be obtained while the Member is in labor, within twenty-four (24) hours of delivery, post abortion, or if the Member is seeking to obtain or obtaining an abortion.[8]

      3) Written informed consent must have been given at least 30 days and no more than 180 days before the procedure is performed.[9] A copy of the consent form must be given to the Member.[10]

      4) A hysterectomy requires an additional consent form and is only covered when medically necessary. A hysterectomy is not compensated under the Medi-Cal program if performed or arranged for the sole purpose of rendering the Member

[2] 22 CCR § 51305.1
[3] 22 CCR § 51305.4
[4] https://www.iehp.org/en/providers/provider-resources?target=forms
[5] 22 CCR § 51305.3
[6] 22 CCR § 51305.4
[7] Ibid.
[8] 22 CCR § 51305.3
[9] 22 CCR § 51305.1
[10] 22 CCR § 51305.3

sterile.

5) Sterilization may be performed during emergency abdominal surgery or premature delivery if the Member consented to sterilization at least 30 days prior to the intended date of sterilization or the expected date of delivery and at least 72 hours have passed between the time that written consent was given and the time of the emergency surgery or premature delivery.[11] The consent must also have been signed 72 hours prior to the Member having received any preoperative medication.

6) The PM 330 Sterilization Consent Form must be fully completed at the time of the procedure.

7) Original copies of the informed consent must be filed in the Member's medical record.

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[11] 22 CCR § 51305.3

5. MEDICAL CARE STANDARDS

F. Family Planning Services

***APPLIES TO*:**

A. This policy applies to all IEHP Covered Members.

POLICY:

A. Medi-Cal Members have the right to access, without prior authorization, any qualified family planning Practitioner within or outside of the IEHP or the Member's Plan's network.

DEFINITIONS:

A. Family Planning Services - Services provided to individuals of child-bearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents.

B. Qualified Family Planning Practitioner - A Provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal Provider, and is willing to furnish family planning services to a Member.

PROCEDURES:

Family Planning Services

A. According to IEHP's Division of Financial Responsibility (DOFR), professional services associated with family planning are the Plan's responsibility. This responsibility includes payment for services accessed by Medi-Cal Members at any qualified family planning Practitioner. IEHP is responsible for the facility charges resulting from qualifying inpatient family planning services.

B. The following list of services may be provided to IEHP Medi-Cal Members as part of the family planning benefit:

   1. Health education and counseling necessary to make informed choices and understand contraceptive methods;

   2. History and physical examination limited to immediate problem;

   3. Laboratory tests, if medically indicated as part of decision-making process for choice of contraceptive methods;

   4. Diagnosis and treatment of Sexually Transmitted Infections (STIs);

   5. Screening, testing, and counseling of at-risk individuals for HIV and referral for treatment;

   6. Follow-up care for complications associated with contraceptive methods issued by the family planning Provider;

7. Provision of contraceptive pills or patches, vaginal rings, devices, and supplies in an on-site clinic and billed by a qualified family planning Provider or Practitioner. The formulary status and quantity limit are determined based on guidance from Department of Health Care Services (DHCS).
8. Tubal ligation;
9. Vasectomy; and
10. Pregnancy testing and counseling.

C. IEHP will cover up to a 12 month supply of Food and Drug Administration (FDA)-approved, self-administered hormonal contraceptives when dispensed or furnished at one time by a Provider or Pharmacist or at a location licensed or authorized to dispense drugs or supplies. The following are not considered part of family planning services:

1. Facilitating services such as transportation, parking, and childcare while family planning care is being obtained;
2. Infertility studies or procedures provided for the purpose of diagnosis or treating infertility;
3. Reversal of voluntary sterilization;
4. Hysterectomy for sterilization purposes only;
5. Therapeutic abortions and related services; and
6. Spontaneous, missed, or septic abortions and related services.

D. A Physician, Physician Assistant, Certified Nurse Midwife, and Nurse Practitioner are authorized to dispense medication. A registered nurse who has completed required training may also dispense contraceptives when Evaluation and Management (E&M) procedure 99201, 99211, or 99212 is performed and billed with modifier 'TD.'

Freedom of Choice

A. Members must be provided with sufficient information to allow them to make informed choices regarding the types of family planning services available, and their right to access these services in a timely and confidential manner. Medi-Cal Members are informed upon enrollment that they have a right to access family planning services within and outside IEHP's network without prior authorization.

B. Members receive family planning and freedom of choice information from IEHP in the following ways:

1. Member Handbook;
2. Relevant IEHP Health Education programs and materials;
3. Member Newsletter; and
4. Member Services contacts.

Informed Consent

A. Practitioners must furnish Members with sufficient information, in terms that a Member can understand, so that an informed decision can be made. All IEHP and out-of-network family planning services Practitioners must obtain informed consent for all contraceptive methods, including sterilization.[1] A sample informed consent for contraceptive methods other than sterilization is attached (See "Attachments/Contraceptive Informed Choice Form – English" and "Contraceptive Informed Choice Form – Spanish" found on the IEHP website.[2] If the Member is unable to give consent, their legal guardian must make appropriate care decisions as needed.

B. Practitioners are required to keep copies of signed informed consent forms in the Member's medical record as well as submit these with any claim forms.[3]

Accessing Family Planning Services

A. Medi-Cal Members select a qualified family planning Practitioner of their choice within the IEHP network or out-of-network. IEHP Member Services refers Members who request additional information to the State Office of Family Planning at (916) 650-0414 to receive more information on qualified family planning Practitioners.

B. Minors aged 12 and older may access family planning services without parental consent.[4] Please see Policy 4E, "Access to Services with Special Arrangements" for more information.

C. Out-of-network family planning practitioners are expected to demonstrate a reasonable effort to coordinate services with IEHP network Practitioners, including educating Members to return to their Primary Care Provider (PCP) for continuity and coordination of care.

D. Members should be encouraged to approve release of their medical records from the family planning provider to the PCP so that the PCP may coordinate future care accordingly and avoid duplication of already provided services. A sample release form for out-of-network family planning services is attached, See "Attachments/Auth or Refusal to Release Medical Record – Out-of-Network Family Planning – English" and "Auth or Refusal to Release Medical Record – Out-of-Network Family Planning – Spanish" found on the IEHP website.[5]

E. If they desire, Members may sign a modified release of information form that preserves their medical record confidentiality but allows family planning service Practitioners adequate information to bill the Member's Plan. Practitioners must make such a form available to Members. A sample form in both English and Spanish is attached, See "Attachments/ Authorization for Use and Disclosure of Personal Health Information – English" and "Authorization for Use and Disclosure of Personal Health Information – Spanish" found on

[1] Ibid.
[2] https://www.iehp.org/en/providers/provider-resources?target=forms
[3] Title 22, California Code of Regulations (CCR) § 51305.3
[4] CA Family Code (Fam. Code) § 6925
[5] https://www.iehp.org/en/providers/provider-resources?target=forms

the IEHP website.[6]

Coordination of Care

A. Listed below are the roles and responsibilities of the PCP, out-of-network family planning Practitioner, the Member's Plan and IEHP staff in coordinating care for Medi-Cal Members accessing out-of-network practitioners for family planning.

1. If a release is signed, and the Member needs care as a follow-up to the family planning services or due to a complication of the family planning service, the out-of-network practitioner must contact the PCP or the Member's Plan Care Management (CM) department.

2. The Member's assigned PCP is responsible for providing or coordinating any additional health care needed by the Member and/or documenting in the medical record any family planning services received by the Member (e.g., cervical cancer screening, type of birth control method) upon receiving medical records from or being informed by the family planning practitioner or Member.

3. If informed by a family planning practitioner that follow-up is needed for a Member, the Member's Plan CM is responsible for informing the PCP and ensuring that all necessary follow-up or additional services are arranged for through the PCP or specialty Practitioner as indicated.

4. If IEHP CM is informed by a family planning practitioner, or by the Member directly, that additional health care services are needed, IEHP CM contacts the Member's Plan CM to coordinate care.

Out-of-Network Family Planning Services Reimbursement

A. Family planning services, including related STI (including HIV) and laboratory testing, provided through Local Health Department (LHD) clinics and out-of-network family planning practitioners, are reimbursed at the Medi-Cal fee-for-service rate unless otherwise negotiated in subcontracts with IEHP Providers.

B. Conditions for Reimbursement

1. The family planning practitioner must submit claims to the Member's Plan or the IEHP Claims Department on a CMS 1500 form, using the appropriate CPT and ICD codes.

2. The family planning practitioner must provide proof of service. If a Member refuses the release of medical information, the out-of-network practitioner must submit documentation of the refusal.

3. IEHP must issue payment for family planning claims within 30 business days of receiving the claim.

4. Family planning billing grievances are resolved in accordance with the Provider

[6] https://www.iehp.org/en/providers/provider-resources?target=forms

Grievance Process.

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APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. All Members have the right to seek treatment for sexually transmitted infections (STIs) from their Primary Care Providers (PCPs), the San Bernardino and Riverside County Local Health Department (LHD) clinics, qualified family planning Practitioners, or any other Practitioner who treats STIs within their scope of practice. Services may be obtained from a Practitioner within or outside the IEHP network without prior authorization.[1]

PROCEDURES:

A. IEHPand all Providers are required to follow the latest Sexually Transmitted Infection (STI) treatment guidelines recommended by the U.S. Centers for Disease Control and Prevention (CDC) as published in the Mortality and Morbidity Weekly Report (MMWR).

B. Licensed Physicians, Nurse Practitioners, Certified Nurse Midwives, or Physician Assistants who are practicing within their authorized scope of practice may prescribe, dispense, furnish, or otherwise provide prescription antibiotic medications to the sexual partner or partners of a Member with a diagnosed sexually transmitted chlamydia, gonorrhea or other sexually transmitted infection, as determined by the California Department of Health Care Services (DHCS), without examination of the Member's sexual partner or partners.[2]

C. Medi-Cal Members may make their own appointment with the STI services Practitioner of their choice. Members may call IEHP Member Services at 1-800-440-IEHP (4347) for assistance with accessing STI services. IEHP encourages Members to return to their PCPs to maintain continuity of care.

Access Within Network

A. Medi-Cal Members may choose to receive STI services from any qualified Practitioner, in IEHP's network or their assigned Plan's network without prior authorization.[3]

B. PCPs are required to offer all Members appropriate STI services, including screening, counseling, education, diagnosis, and treatment.

Access Out-of-Network

A. Members may access STI services from an out-of-network qualified practitioner without prior authorization.[4]

B. Out-of-network practitioners may call IEHP Member Services at 1-800-440-IEHP (4347) for

[1] California Health & Safety Code (Health & Saf. Code) § 1367.31
[2] California Health and Safety Code (Health & Saf. Code) § 120582
[3] CA Health & Saf. Code § 1367.31
[4] CA Health & Saf. Code § 1367.31

Medi-Cal eligibility, benefits, benefit exclusions, limitations, and the name of the Member's IEHP PCP. IEHP encourages the out-of-network practitioner to refer the Member back to their PCP to maintain continuity of care.

Confidentiality and Reporting

A. Members aged 12 years and older, may access STI services from Practitioners noted above without parental consent.[5] See Policy 4E, "Access to Services with Special Arrangements" for more information.

B. The expressed, written consent of the Member or legal representative is required for the release of medical records to another party outside the Practitioner. If they desire, Members may sign a modified release of information form that preserves their medical record confidentiality but gives STI service Practitioners adequate information for billing purposes. Practitioners must make such a form available to their Members(see Attachments "Authorization for Use and Disclosure of Personal Health Information – English" and "Authorization for Use and Disclosure of Personal Health Information – Spanish" found in the IEHP website.[6]

C. All Practitioners providing STI services are required by law to report individuals with certain communicable diseases to the LHD. See Policy 5J, "Reporting Communicable Diseases to Public Health Authorities."

D. Medical records for Members presenting for STI evaluation must be maintained to protect the confidentiality of the Member.[7] In-network Practitioners must adhere to IEHP Medical Records policies and procedures. See Policy 3A, "Provider Medical Record Requirements."

Coordination of Care

A. PCPs are responsible for coordinating care and avoiding duplicate service delivery and/or release of medical records for those Members that receive STI treatment outside of the network. In those cases, the PCP is responsible for determining what services were received by the Member, recording or placing in the medical record all pertinent information (assuming consent from the Member) and determining any need for follow-up care, testing or treatment.

B. PCPs are responsible for notifying the Member's Plan Case Management (CM) staff when Members consent to release of information and require case management services due to their STI or medical condition complexity. IEHP or its Plan's CM is then responsible for coordinating care including, but not limited to, referral to specialists and transfer of additional medical information.

Reimbursement for Out-of-Network Services

A. IEHP contracts define STI services as an Plan's responsibility. This responsibility includes payment for services accessed by Medi-Cal Members out-of-network.

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[5] CA Family Code (Fam. Code) § 6926
[6] https://www.iehp.org/en/providers/provider-resources?target=forms
[7] Ibid.

B. The reimbursement for out-of-network practitioners not associated with a LHD for STI services is limited to one (1) office visit per disease episode for:

   1. Diagnosis and treatment of vaginal discharge and urethral discharge;
   2. Evaluation and treatment initiation for treatment of Pelvic Inflammatory Disease (PID);
   3. Those STIs that are responsive to immediate diagnosis and treatment:
      a. syphilis
      b. chlamydia
      c. chancroid
      d. human papilloma virus
      e. lymphogranuloma venereum
      f. gonorrhea
      g. herpes simplex
      h. Trichomoniasis
      i. non-gonococcal urethritis
      j. granuloma inguinale

C. For LHDs, reimbursement is available as outlined below:

   1. One (1) visit is reimbursable for initial treatment of vaginal or urethral discharge for symptoms and signs consistent with trichomoniasis.
   2. Up to six (6) visits are reimbursable for primary and secondary syphilis clinical and serological follow-up and treatment. Documentation should include serologic test results upon which treatment recommendations were made. Members found to have reactive serology while showing no other evidence of disease should be counseled about the importance of returning to a Provider or Practitioner for follow-up and treatment of possible latent syphilis.
   3. Initial visit and up to two (2) follow-up visits are reimbursable for chancroid diagnosis and clinical improvement confirmation.
   4. A maximum of three (3) visits are reimbursable for lymphogranuloma or granuloma inguinale, based upon the time involved to confirm the diagnosis and the necessary therapy duration necessary.
   5. One (1) visit is reimbursable for presumptive diagnosis and treatment of herpes simplex.
   6. Gonorrhea, non-gonococcal urethritis, and chlamydia can often be presumptively diagnosed and treated in one (1) visit. For individuals with gonorrhea or chlamydia not presumptively treated at the first visit, a second visit for treatment is reimbursed.
   7. One (1) visit is reimbursable for diagnosis and therapy initiation for human papilloma virus, with referral to PCP for further follow-up and treatment.
   8. Initial visits and two (2) follow-up visits for pelvic inflammatory disease diagnosis, treatment, and urgent follow-up are reimbursable. Members should be referred to their PCP for continued follow-up after the initial three (3) visits have been provided by the

LHD.

D. STI services and laboratory testing provided through out-of-network practitioners must be reimbursed at the Medi-Cal fee-for-service (FFS) rate, unless otherwise negotiated in subcontracts with Plan.

E. Guidelines for treatment of various STIs may require that HIV testing and counseling be performed. These tests and counseling procedures are reimbursed at the appropriate Medi-Cal FFS rate. See Policy 5H, "HIV Testing and Counseling" for specific information on HIV testing and counseling procedures.

F. Conditions for Reimbursement

   1. The out-of-network practitioner must submit claims to the Member's assigned Plan or the IEHP Claims Department on CMS 1500 or UB-04 billing forms using the appropriate CPT and ICD codes that reflect STI diagnosis and treatment.
   2. The STI treating Practitioner must provide proof of service. If a Member refuses the release of medical information, the treating Practitioner must submit refusal documentation.
   3. STI treating Practitioners are not reimbursed for services that fall outside the specific conditions and visits noted above.
   4. STI treating Practitioners are only reimbursed for services provided by a Practitioner within their licensed scope of practice.
   5. STI treating Practitioners are only reimbursed for services provided to IEHP Member.

G. IEHP must pay claims within 30 days of claims receipt.

H. Practitioners providing STI services who wish to register a complaint regarding non-payment, underpayment, or any billing related issue may do so by contacting the IEHP Provider Relations Team at (909) 890-2054.

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APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. IEHP requires Primary Care Providers (PCPs) to screen for HIV infection in alignment with recommendation from the United States Preventive Services Task Force (USPSTF).[1]

B. Members may access without prior authorization confidential HIV testing and counseling services within their Plan's network or through a Local Health Department (LHD) and family planning providers. [2]

PROCEDURES:

A. IEHP and Providers are required to follow all State laws governing consent for testing and disclosure of HIV test results, as well as the most up-to-date guidelines for HIV counseling, testing, treatment, and referral recommended by the U.S. Centers for Disease Control and Prevention (CDC).[3]

B. IEHP provides all IPAs and PCPs with an updated list of LHD operated or contracted HIV testing and counseling sites. See "Attachment/HIV Testing Sites – Riverside and San Bernardino" found on the IEHP website.[4]

C. IEHP contracts define HIV testing and counseling as Plan responsibility. This responsibility includes payment of services accessed by the Member out-of-network.

Access to HIV Counseling and Testing Services

A. The assessment for HIV infection screening can occur in the following situations:

   1. As part of a well-child or adult physical exam;
   2. At the time of a visit for illness or injury;
   3. At the request of a Member, Member's parent or guardian; or
   4. Other appropriate circumstances.

[1] United States Preventive Services Task Force (USPSTF), Screening for HIV Infection: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening
[2] California Health and Safety Code (Health & Saf. Code) § 1367.46
[3] CDC HIV Testing Guidelines: https://www.cdc.gov/hiv/guidelines/testing.html
[4] https://www.iehp.org/en/providers/provider-resources?target=forms

B. The assessment performed by the PCP must align with the most up-to-date recommendations from the CDC.[5]

C. For those Members identified by the PCP as at risk for HIV infection, one (1) of the following must occur:

1. PCP provides HIV testing and counseling; or
2. PCP refers the Member, or the Member can self-refer to a LHD-operated or contracted HIV testing and counseling site for confidential or anonymous services.

D. 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. See Policy 7A1, "Case Management Requirements – PCP Role."

E. Medi-Cal Members can also access HIV testing and counseling services directly and without prior authorization under the following circumstances:

1. As part of a Family Planning visit with any qualified family planning Practitioner. See Policy 5F, "Family Planning Services";
2. As part of an STI visit at a LHD or other qualified Practitioner. See Policy 5G, "Sexually Transmitted Infection (STI) Services"; or
3. Direct self-referral for anonymous or confidential HIV testing and counseling services at a LHD operated or contracted site.

F. IEHP Member Services is available to assist Members who request access to HIV testing and counseling services by informing them of their options described above and/or referring them to LHD operated or contracted sites.

HIV Testing and Counseling for Children

A. PCPs and Specialists caring for Members who are children must offer to parents or legal guardians HIV counseling, education, and testing, where appropriate, to infants, children and adolescents in the following categories:

1. Infants and children of HIV seropositive mothers;
2. Infants and children of mothers at high risk for HIV infection with unknown HIV serologic status including:
   a. Children born with a positive drug screen;
   b. Children born to mothers who admit to present or past use of illicit drugs;
   c. Children born with symptoms of drug withdrawal;
   d. Children born to mothers who have arrests for drug-related offenses or prostitution;
   e. Children born to mothers with any male partners at high risk for HIV; and

[5] CDC HIV Screening in Clinical Settings: https://www.cdc.gov/hiv/clinicians/screening/clinical-settings.html

    f. Any abandoned newborn infants.

3. Sexually abused children and adolescents;
4. Adults receiving blood transfusion/blood products as children between 1977-1985 or symptomatic children receiving transfusions since 1985;
5. Adolescents who engage in high-risk behaviors including unprotected sexual activity, illicit drug use, or who have had STIs; and
6. Other children deemed at high risk by a Practitioner.

B. Medi-Cal Members that are under the age of 21 years who are confirmed HIV positive must be referred to the California Children's Services (CCS) Program.

HIV Testing, Counseling and Follow-up for Pregnant Members

A. IEHP network Practitioners who provide perinatal care must comply with USPSTF HIV screening recommendations and state regulations, which require the health care professional primarily responsible for providing prenatal care to a pregnant Member to offer HIV information and counseling to every pregnant Member, including, but not limited to:[6]
   1. Mode of transmission;
   2. Risk reduction and behavior modification including methods to reduce the risk of perinatal transmission; and
   3. Referral to other HIV prevention and psychosocial services.

B. IEHP requires that all prenatal care Practitioners within its network and that of Plans to offer HIV testing to every pregnant Member; unless the Member has a positive test result documented in the medical record or has AIDS as diagnosed by a Practitioner.[7]

C. All IEHP prenatal care Practitioners are required to discuss with the Member:
   1. The purpose of the HIV test;
   2. Potential risks and benefits of the HIV test, including treatment to reduce transmission to the newborn; and
   3. That HIV Testing is voluntary.

D. Practitioners must document in the Member's medical record that education, counseling, and testing was offered to the pregnant Member.

Out-of-Network Reimbursement for Medi-Cal Members

A. HIV testing and counseling services provided through LHDs, sites subcontracted by LHDs or qualified family planning Practitioners as part of a family planning visit must be reimbursed at the Medi-Cal fee-for-service rate, unless otherwise negotiated between Practitioners.

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[6] CA Health & Saf. Code § 125107
[7] USPSTF, Screening for HIV Infection: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening

B. Out-of-network practitioners must submit claims to the Member's assigned Plan or the IEHP Claims Department on CMS 1500 billing forms using appropriate CPT and ICD codes.

C. Out-of-network practitioners must provide proof of service adequate for audit purposes.

D. IEHP must pay claims within 30 days of receipt.

E. All out-of-network practitioner HIV testing and counseling claims grievances are resolved per the IEHP Provider Grievance Process.

Medical Records

A. All documentation in Member's charts and release of information regarding HIV tests must maintain patient confidentiality and privacy in alignment with state and federal regulations.[8] Confidentiality guidelines are set forth below:

1. The Practitioner ordering the test may record the results in the subject's medical record and disclose the results to other Practitioners for purposes of diagnosis, care or treatment without the subject's written authorization.[9]
2. The Practitioner ordering the test may **not** disclose the results of the test to IEHP, the Member's Plan or any other health care service plan.[10,11]
3. All records reflecting HIV testing must be kept in a locked cabinet accessible only by authorized personnel.

Consent of HIV Testing and Disclosure of HIV Test Results

A. All Practitioners ordering HIV tests must either obtain written consent or informed verbal consent from the Member.[12] IEHP provides sample consent forms that may be used. See "Attachments/Consent for HIV Test – English" and "Consent for HIV Test – Spanish" found on the IEHP website.[13] These are also available online at www.iehp.org. Informed verbal consent is only sufficient when a treating Practitioner orders the test.

B. Except in cases where direct health care Practitioners are disclosing the results of an HIV test for purposes directly related to the Member's health care,[14] all IEHP network Practitioners must obtain written consent from the Member to disclose HIV test results. See "Attachments/Authorization for Use and Disclosure of Personal Health Information – English" and "Authorization for Use and Disclosure of Personal Health Information – Spanish" and "Authorization for Use and Disclosure of Personal Health Information" forms can be found on the IEHP website.[15]

[8] CA Health & Saf. Code, § 120975
[9] CA Health & Saf. Code, § 120985
[10] Ibid.
[11] CA Health & Saf. Code, § 121010
[12] CA Health & Saf. Code, § 120990
[13] https://www.iehp.org/en/providers/provider-resources?target=forms
[14] CA Health & Saf. Code, § 120985
[15] https://www.iehp.org/en/providers/provider-resources?target=forms

Reporting

A. All Practitioners are required to comply with state law and report all known AIDS cases to the Local Health Department. See Policy 5J, "Reporting Communicable Diseases to Public Health Authorities."

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5. MEDICAL CARE STANDARDS

I. Tuberculosis Services

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. Primary Care Providers (PCPs) must perform tuberculosis (TB) screening, diagnosis, treatment, and follow-up as well as provide TB care and treatment in compliance with the most recent recommended guidelines from the American Thoracic Society and the Centers for Disease Control and Prevention (CDC).[1,2,3,4]

DEFINITIONS:

A. Direct Observation Therapy (DOT) – A course of treatment, or preventive treatment, for Tuberculosis in which the prescribed course of medication is administered to the person or taken by the person under direct observation by a trained healthcare worker.[5]

PROCEDURES:

Provider Responsibilities

A. Risk Assessment

   1. PCPs must assess Members for risk factors for developing TB at a minimum during these encounters:

      a. Well child visits. See Policy 5C1, "Pediatric Preventive Services – Well Child Visits"); and

      b. Initial Health Assessment. See Policy 5A, "Initial Health Assessment".

   2. All IEHP Members with an increased risk of TB must be offered TB testing unless they have documentation of prior positive test results or TB disease.

B. Screening and Diagnosis

   1. PCPs must initiate and perform diagnostic work-up for Members suspected of having active TB per the most recent CDC guidelines.[6]

   2. All sputum specimens submitted for culture, including identification and sensitivity, must be directed to a laboratory, preferably a Local Health Department (LHD) laboratory.

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[1] Memorandum of Understanding (MOU) between IEHP and Riverside University Health System (RUHS), Public Health Services, 06/01/14
[2] MOU between IEHP and San Bernardino County Department of Public Health (SBDPH), Health Services for Medi-Cal Members, 07/01/07
[3] https://www.thoracic.org/statements/tuberculosis-pneumonia.php
[4] https://www.cdc.gov/tb/publications/guidelines/default.htm
[5] https://www.cdc.gov/tb/programs/laws/menu/treatment.htm#observedTherapy
[6] https://www.cdc.gov/tb/publications/guidelines/default.htm

Laboratories must report to the LHD testing results, including molecular and pathologic results, suggesting of diseases of public health importance.[7,8,9] See Policy 5J, "Reportable Communicable Diseases to Public Health Authorities."

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San Bernardino County	(800) 722-4794

3. Members who test positive and have no evidence of active TB, must be educated about TB prevention, per the most recent CDC guidelines. [10]

C. Public Health Reporting

1. Providers must report all confirmed (TB3) or highly suspected (TB5) active TB cases to the LHD in the county <u>where the Member resides.</u> [11] See Policy 5J, "Reporting Communicable Diseases to Public Health Authorities" for reporting guidelines.

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2. Hospital infection control staff, including the attending physician, are required to notify LHDs prior to discharge or transfer of an inpatient case of active TB.[12]

3. PCPs must cooperate with LHD in conducting contact tracing and outbreak investigations potentially involving Members, as well as for any requests for medical records, screening, diagnostic work-up, and any other pertinent clinical or administrative information.[13,14]

4. PCPs must provide appropriate examination and treatment to Members, identified by the LHD as contacts. These must be provided in a timely manner (usually within seven (7) days). Examination results must be reported back to the LHD Tuberculosis Program staff in a timely manner, as defined by the LHD. [15,16]

5. Providers are encouraged to enroll in the California Reportable Disease Information Exchange (CalREDIE). The CalREDIE is a system that the California Department of Public Health has implemented for electronic disease reporting and surveillance.

D. Direct Observed Therapy (DOT)

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[7] Title 17, California Code of Regulations (CCR) § 2505
[8] MOU between IEHP and RUHS, Public Health Services, 06/01/14
[9] MOU between IEHP and SBDPH, Health Services for Medi-Cal Members, 07/01/07
[10] https://www.cdc.gov/tb/publications/guidelines/default.htm
[11] 17 CCR § 2500
[12] California Health and Safety Code (Health & Saf. Code) § 121361
[13] MOU between IEHP and RUHS, Public Health Services, 06/01/14
[14] MOU between IEHP and SBDPH, Health Services for Medi-Cal Members, 07/01/07
[15] MOU between IEHP and RUHS, Public Health Services, 06/01/14
[16] MOU between IEHP and SBDPH, Health Services for Medi-Cal Members, 07/01/07

1. The following groups of individuals are at risk for difficulty adhering to the treatment of TB. Providers shall refer Members with active TB and have any of these risks to the LHD:
   a. Members with demonstrated multiple drug resistance (defined as resistance to Isoniazid and Rifampin);
   b. Members whose treatment has failed or who have relapsed after completing a prior regimen;
   c. Children and adolescents; and
   d. Individuals who have demonstrated difficulty adhering to treatment (those who failed to keep office appointments).
2. Providers shall assess the following Members for consideration for DOT through the LHD:
   a. Substance users;
   b. Persons with mental illness;
   c. The elderly;
   d. Persons with unmet housing needs; and
   e. Persons with language and/or cultural barriers.

   If, in the opinion of the Provider, a Member with one (1) or more of these risk factors is at risk for difficulty adhering to treatment, the Provider must refer the Member to the LHD for DOT.
3. For Members receiving DOT, the PCP must share clinical information with the LHD Tuberculosis Program as needed and requested. The PCP must promptly notify the LHD Tuberculosis Program of any significant changes in the Member’s condition or response to medical treatment including adverse drug reactions and dosage changes. IEHP provides all medically necessary medication for Members with TB.

IEHP Responsibilities

A. IEHP provides case management and care coordination for all suspected and active TB cases. IEHP CM provides the coordination of TB care with the LHD.

B. IEHP continues to provide all medically necessary covered services to Members with TB on DOT and ensures joint case management and coordination of care with the LHD.

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J. Reporting Communicable Diseases to Public Health Authorities

APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. Providers must report known and suspected cases of communicable disease to public health authorities in the county where the Member resides.[1]

PURPOSE

A. To allow timely reporting to public health authorities to determine morbidity, evaluate transmission risk and intervene appropriately to minimize transmission.

PROCEDURES:

A. Providers must use the following guidelines to report a case or suspected case to the appropriate public health authority:

1. Extremely Urgent Conditions should be reported immediately by telephone, twenty-four (24) hours a day, to the after-hour emergency number listed in this policy. See Attachments/Reportable Diseases and Conditions – Riverside" and "Reportable Diseases and Conditions – San Bernardino" found on the IEHP website.[2,3]

2. Other Urgent Conditions should be reported by telephone, mail or electronically submitted within one (1) working day of identifying a case or suspected case (See Attachments, "Reportable Diseases and Conditions – Riverside" and "Reportable Diseases and Conditions – San Bernardino" found on the IEHP website).[4,5]

3. All Other Non-Urgent Conditions may be reported by phone or mail on confidential morbidity report cards within seven (7) calendar days of identification. See "Attachments/ "Reportable Diseases and Conditions – Riverside" and "Reportable Diseases and Conditions – San Bernardino" found on the IEHP website.[6,7]

B. Animal bites by a species susceptible to rabies are reportable, to identify persons potentially requiring prophylaxis for rabies. Additionally, vicious animals are identified and may be controlled by this regulation and local ordinances.[8] Reports can be filed with the local Animal Control Agency or Humane Society. The County Animal Control office may assist in filing

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[1] Title 17, California Code of Regulations (CCR) § 2500(b)
[2] 17 CCR § 2500(h)
[3] https://www.iehp.org/en/providers/provider-resources?target=forms
[4] Ibid.
[5] https://www.iehp.org/en/providers/provider-resources?target=forms
[6] Ibid.
[7] https://www.iehp.org/en/providers/provider-resources?target=forms
[8] Ibid.

the report:

1. Riverside County - (951) 358-7327
2. San Bernardino County - (800) 472-5609

C. Providers are encouraged to participate in the California Reportable Disease Information Exchange (CalREDIE). The CalREDIE is a system that the California Department of Public Health has implemented for electronic disease reporting and surveillance.

D. The report to the public health authorities shall be documented in the Member's medical record and include the report date, the contact at the public health authority and the reporter's signature.

E. Local Health Departments (LHD) are responsible for receiving disease reports and coordinating follow-up action between local, regional, and state officials. In some cases, reporting requirements may differ slightly from one county to the next. Questions about communicable disease reporting should be directed to the LHD.

Riverside County

Riverside: (951) 358-5107
(951) 358-5102 (confidential fax)

Disease Control Branch
P.O. Box 7600
Riverside, CA 92513-7600

Night & Weekend Emergency: (951) 358-5107

San Bernardino County

San Bernardino County: (800) 722-4794
(909) 387-6377 (fax)

Communicable Disease Section
351 N. Mountain View Ave
San Bernardino, CA 92415

Night & Weekend Emergency: (909) 356-3805

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5. MEDICAL CARE STANDARDS

K. Vision Examination Level Standards

APPLIES TO:

A. This policy applies to IEHP Covered Members.

POLICY:

A. IEHP's commitment to providing quality care to Members requires that certain tests be performed during comprehensive and intermediate ophthalmological exams.

PROCEDURES:

A. **Comprehensive Exam**- A comprehensive ophthalmological examination provides a complete history and physical evaluation of the ocular system. The examination may be performed with or without dilation. A comprehensive exam must document each of the following:

1. Case History to include personal medical history, including review of systems (ROS); personal ocular history; family medical history; family ocular history;
2. Qualitative Assessment of Vision: entering visual acuity, either with or without existing correction;
3. Binocular Function testing to include at least two (2) of the following: stereo test; phorias-horizontal and vertical; vergences; prism reflex test; cover testing; near point of convergence (NPC); accommodation Negative Relative Accommodation (NRA)/ Positive Relative Accommodation (PRA);
4. Health status of the complete visual system including: tonometry; gross visual fields; biomicroscopy; pupillary reflexes; extraocular muscle assessment; ophthalmoscopy; mydriasis, when indicated and necessary; and
5. Initiation of any other necessary diagnostics or treatment procedure/programs.

B. **Intermediate Exam**- An intermediate ophthalmological examination for a new or existing Member must document each of the following:

1. Case History- specifically the reason for the visit and pertinent medical history; personal medical history, including review of systems (ROS); personal ocular history; family medical history; family ocular history;
2. Qualitative Assessment of Vision- entering visual acuity; either with or without existing correction;
3. Health status of the complete visual system including- tonometry; gross visual fields; biomicroscopy; pupillary reflexes; extraocular muscle assessment; ophthalmoscopy; mydriasis, when indicated and necessary; and
4. Other diagnostic procedures as indicated and necessary.

C. **Determination of Refractive State-** The determination of refractive state for a new or existing Member must document each of the following:

1. Objective refraction results;
2. Subjective refraction results; and
3. Best corrected visual acuity (BCVA).

D. IEHP recognizes the importance of allowing Members to have prompt diagnosis and treatment of acute eye conditions. Under the Therapeutic Pharmaceutical Agent (TPA) Certification Program, IEHP-credentialed and TPA-certified Providers may provide specific services to Members without a referral from the Member's PCP. 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-credentialed Ophthalmology Providers should continue to work through their contracted Plan to provide these services.

E. To ensure Member continuity of care, all Providers participating in the TPA Program are responsible for notifying the Member's PCP that medical services have been provided. For more information on the TPA Program. See Policy 7H, "Vision Services."

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5. MEDICAL CARE STANDARDS

L. Mandatory Elder or Dependent Adult Abuse Reporting

APPLIES TO:

A. This policy applies to Mandated Reporters who treat or have contact with IEHP Covered Members.

POLICY:

A. Any Mandated Reporter who, in his or her professional capacity, or within the scope of his/her employment, has observed or has knowledge of an incident that reasonably appears to be abuse, neglect, or financial abuse, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse, neglect, or financial abuse, or reasonably suspects that abuse, neglect, or financial abuse has occurred is required by law to report directly to appropriate county agencies by telephone immediately or as soon as practicably possible.[1]

B. **Exceptions**: Physicians and Surgeons, Registered Nurses, and Psychotherapists are NOT required to report incidents of an elder or dependent adult abuse when **all** the following exist:[2]

   1. The Mandated Reporter has been informed by the elder or dependent adult that he or she has experienced abuse; and
   2. The Mandated Reporter is not aware of any independent evidence that corroborates the statement that the Abuse has occurred; and
   3. The elder or dependent adult had been diagnosed with a mental illness or dementia; and
   4. In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist reasonably believes that the abuse did not occur.

DEFINITIONS:

A. **Abuse** – Physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering of an elder or dependent adult . Abuse is also the deprivation to an elder or dependent adult by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.

   1. **Abandonment** – the desertion or willful forsaking of an elder or dependent adult by anyone having care of custody of that person when a reasonable person would continue to provide care and custody.
   2. **Abduction –** the removal from this state and/or the restraint from returning to this state, of any elder or dependent adult who does not have the capacity to consent to such removal and/or restraint from returning. This also applies to the removal or restraint of any conservatee without the consent of the conservator or the court.
   3. **Financial Abuse** – the taking or assistance in taking real or personal property of a elder

[1] California Welfare and Institutions Code (Welf. & Inst. Code) § 15630(b)(1)
[2] CA Welf. & Inst. Code § 15630(b)(3)(A)

or dependent adult by undue influence, or for a wrongful use or intent to defraud the elder or dependent adult.

4. **Isolation** – acts intentionally committed to prevent the elder or dependent adult from receiving mail, telephone calls, and callers/visitors (when that is contrary to the wishes of the elder or dependent adult). These activities will not constitute isolation if performed pursuant to a physician and surgeon's instructions, who is caring for the elder or dependent adult at the time, or if performed in response to a reasonably perceived threat of danger to property or physical safety.

5. **Neglect** – the negligent failure of any person having the care or custody of the elder or dependent adult to exercise a reasonable degree of care. This includes, but is not limited to, the failure to assist in personal hygiene; provide food, clothing, or shelter; provide medical care for physical and mental health needs; failure to protect from health and safety hazards; and failure to prevent malnutrition or dehydration. Neglect includes self-neglect, which is the elder or dependent adult inability to satisfy the aforementioned needs for himself or herself.

6. **Physical Abuse** – this includes but is not limited to, assault, battery, unreasonable physical constraint, prolonged/continual deprivation of food or water, sexual assault or battery, rape, incest, sodomy, oral copulation, sexual penetration, lewd or lascivious acts; or the use of physical or chemical restraint or psychotropic medication for punishment, for a period beyond that which was ordered by a physician and surgeon providing care, or for any purpose not authorized by the physician and surgeon.

B. **Dependent Adult** – any person between the ages of 18 and 64 years who resides in this state and who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights.[3]

C. **Elder** – any person residing in this state, 60 years or older.[4]

D. **Ombudsman** – the State Long-Term Care Ombudsman, local ombudsman coordinators, and other persons currently certified as ombudsmen by the Department of Aging.

E. **Serious Bodily Injury** – an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ, or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation.

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[3] CA Welf. & Inst. Code § 15610.23
[4] CA Welf. & Inst. Code § 15750(b)(2)

PROCEDURES:

Identification of Suspected Abuse

A. Mandated Reporters must be alert for signs of possible elder or dependent adult abuse including, but not limited to, the following signs and symptoms:

1. Evidence of malnutrition, starvation, dehydration;
2. Chronic Neglect;
3. Sexual assault;
4. Evidence of financial misappropriation or theft from an elder or dependent adult ;
5. Conflicting or inconsistent accounts of incidents and injuries;
6. Depression, not responding to appropriate therapy, or characterized by suicidal thoughts;
7. Blunt force trauma that is not consistent with a fall;
8. Infection due to lack of medical treatment;
9. A series of accidents, bruises, or fractures over time;
10. Unexplained illness or injury;
11. On office visit, the presence of physical findings of trauma inconsistent with a elder or dependent adult stated history, or inconsistent with the caregiver's history. Examples include a stated mechanism of injury not consistent with elder or dependent adult's functional capabilities; and/or
12. On office visit, the presence of behavioral or emotional clues pointing toward possible abuse. These may include excessive hostility between a elder or dependent adult and his/her caregiver; excessively avoidant, sullen, fearful, submissive, or anxious behaviors on the part of the elder or dependent adult .

B. Any obligation to investigate the particulars of any case rests with Adult Protective Services. This allows Mandated Reporters to act based only upon clinical suspicion, without being constrained by the need to investigate or to cast judgment.

Reporting Responsibilities and Time Frames

A. **Suspected Incident of Abuse in a Long-Term Care (LTC) Facility**[5]

1. **Please note**: this section relates to reporting suspected physical abuse which occurred in a long-term care facility but **not** a state mental health hospital or a state development center.
2. If the suspected physical abuse results in serious bodily injury:

[5] CA Welf. & Inst. Code § 15630(b)(1)(A)

a. A telephone report shall be made immediately to the local law enforcement agency, and no later than two (2) hours after observing, obtaining knowledge of, or suspecting physical abuse; and

b. A written report shall be made to the law enforcement agency, local Long-Term Care Ombudsman (LTCOP), and appropriate licensing agency, within two (2) hours of observing, obtaining knowledge of, or suspecting physical abuse.

3. If the suspected physical abuse does **not** result in serious bodily injury:

   a. A telephone report shall be made to the local law enforcement agency within twenty-four (24) hours of observing, obtaining knowledge of, or suspecting physical abuse; and

   b. A written report shall be made to the law enforcement agency, LTCOP, and appropriate licensing agency, within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.

4. If the suspected physical abuse is caused by a resident of the LTC facility who is diagnosed with dementia, and there is no serious bodily injury, the Mandated Reporter shall report to LTCOP or law enforcement agency by telephone, immediately or as soon as practicably possible, and by written report, within twenty-four (24) hours.

B. **Suspected Incident of Abuse (Other Than Physical Abuse) in a Long-Term Care Facility**[6]

1. **Please note**: this section relates to reporting suspected abuse (other than physical abuse) which occurred in a LTC facility but **not** a state mental health hospital or a state development center.

2. If the suspected abuse is other than physical abuse, a telephone report and a written report shall be made to the LTCOP or the local law enforcement agency immediately or as soon as practicably possible. The written report shall be submitted within two (2) working days.[7]

C. **Suspected Incident of Abuse in a State Mental Hospital or a State Development Center**[8]

1. If the suspected abuse resulted in any of the following incidents, a report shall be made immediately, no later than two (2) hours, by the Mandated Reporter observing, obtaining knowledge of, or suspecting abuse to designated investigators of the State Department of State Hospitals or the State Department of Developmental Services, and the local law enforcement agency:

   a. A death.

[6] CA Welf. & Inst. Code § 15630 (b)(1)(B)

[7] https://www.cdss.ca.gov/inforesources/cdss-programs/adult-protective-services/information-for-mandated-reporters

[8] CA Welf. & Inst. Code § 15630 (b)(1)(E)

b. A sexual assault, as defined in CA Welfare & Institutions Code § 15610.63.

c. An assault with a deadly weapon[9] by a nonresident of the state mental hospital or state development center.

d. An assault with force likely to produce great bodily injury.[10]

e. An injury to the genitals when the cause of the injury is undetermined.

f. A broken bone when the cause of the break is undetermined.

2. All other reports of suspected or alleged abuse shall also be made within two (2) hours of the Mandated Reporter observing, obtaining knowledge of, or suspecting abuse to designated investigators of the State Department of State Hospitals or the State Department of Developmental Services, or to the local law enforcement agency.

3. Reports can be made by telephone; A written report shall be sent, or an Internet report, within two (2) working days.

D. **Abuse Outside of a Long-Term Care Facility, State Mental Hospital, or a State Development Center**[11]

1. If the abuse has occurred in any place other than a LTC facility, a state mental hospital, or state development center, the report shall be made to the adult protective services agency or the local law enforcement agency.

2. Reports can be made by telephone or through a confidential Internet reporting tool; if reported by telephone, a written report shall be sent, or an Internet report, within two (2) working days.

E. **Suspected Abuse when a patient transfers to a receiving hospital**

1. If the Admitting Physician or other persons affiliated with a hospital receives a patient, transferred from another health care facility or community health facility, who exhibits a physical injury or condition that appears to be due to the result of abuse or neglect, they must submit a telephonic and written report within 36 hours to both the police and the local county health department.[12]

F. **Suspected Elder or Dependent Adult Abuse Reporting Requirements**

1. The report shall include the following, if known:[13]

a. Name, title, and daytime number of reporting party, agency name and address, and date of report.

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[9] CA Penal Code § 245
[10] Ibid.
[11] CA Welf. & Inst. Code § 15630
[12] CA Penal Code § 11161.8
[13] CA Welf. & Inst. Code § 15658

b. Name, address, age and present location of the Dependent Adult/Elder.

c. Any information that led the reporting party to suspect that Abuse has occurred.

d. Nature and extent of the elder or dependent adult's condition.

e. The date and time of incident.

f. Names and addresses of family members or any other person responsible for the elder or dependent adult's care.

g. Any other information requested by the adult protective agency.

Riverside
Dependent Adult and Elder Abuse:
Adult Services Division
(800) 491-7123 (24 hours)

San Bernardino
Dependent Adult and Elder Abuse:
Department of Aging and Adult Services
(877) 565-2020 (24 hours)

Other Related Responsibilities

A. IEHP is responsible for educating their contracted PCPs and Specialists of the procedures for reporting abuse cases.

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5. MEDICAL CARE STANDARDS

M. Mandatory Child Abuse and Neglect Reporting

APPLIES TO:

A. This policy applies to all Mandated Reporters who treat or have contact with IEHP Covered Members.

POLICY:

A. Any Mandated Reporter who, in his or her professional capacity, or within the scope of his/her employment, has knowledge of or observes a child or reasonably suspects has the been the victim of child abuse or neglect is required by law to report directly to appropriate county agencies by telephone immediately or as soon as practicably possible.[1]

B. Primary Care Providers (PCPs) are responsible for the overall health care of assigned Members including reporting incidents of known or suspected child abuse or neglect cases.

C. No mandated reporter shall be civilly or criminally liable for any report required or authorized by this article, and this immunity shall apply even if the mandated reporter acquired the knowledge or reasonable suspicion of child abuse or neglect outside of his or her professional capacity or outside the scope of his or her employment.[2]

DEFINITIONS:

A. **Child Abuse or Neglect** - includes physical injury or death inflicted by other than accidental means upon a child by another person, sexual abuse, neglect, the willful harming or injuring of a child or the endangering of the person or health of a child, and unlawful corporal punishment or injury.[3]

   1. **Sexual Abuse** - sexual assault or sexual exploitation.

   2. **Neglect** - negligent treatment or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare.

   3. **Willful harming or injuring of a child or the endangering of the person or health of a child** - a situation in which any person willfully causes or permits any child to suffer, or inflicts thereon, unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of the child to be placed in a situation in which his or her person or health is endangered.

   4. **Unlawful corporal punishment or injury** - a situation where any person willfully inflicts upon any child any cruel or inhuman corporal punishment or injury resulting in a traumatic condition.

   5. **Abuse or neglect in out-of-home care** - includes abuse or neglect where the person

[1] California Penal Code, § 11166(a)
[2] California Penal Code, § 11172
[3] California Penal Code, § 11165.5

responsible for the child's welfare is a licensee, administrator, or employee of any facility licensed to care for children, or an administrator or employee of a public or private school or other institution or agency.

6. **Mandated Reporter** – an individual who is required by law to make reports of known or suspected abuse or neglect.[4]
    a. Primary Care Providers (PCP)
    b. Medical, Dental and Hospital Personnel
    c. Mental Health Professionals and Counselors
    d. Social Service Personnel

PROCEDURES:

Identification of Suspected Abuse or Neglect Cases

A. Mandated Reporters must be alert for signs of possible child abuse or neglect including, but not limited to, the following signs and symptoms:
    1. Evidence of malnutrition, starvation, dehydration, failure to thrive;
    2. Chronic neglect;
    3. Sexual assault;
    4. Exposure to controlled substances, street drugs, or alcohol;
    5. Conflicting or inconsistent accounts of incidents and injuries;
    6. Depression not responding to appropriate therapy or characterized by suicidal thoughts;
    7. Shaken baby syndrome;
    8. Blunt force trauma;
    9. Infection due to lack of medical treatment;
    10. A series of accidents, bruises, or fractures over time;
    11. Unexplained illness or injury;
    12. Signs of human trafficking/exploitations, such as inappropriate sexualized behavior;
    13. Poor or worsening school or work performance not otherwise explained;
    14. On office visit, the presence of physical findings of trauma inconsistent with a Member's stated history, or inconsistent with the parent's, caregiver's, or guardian's history. Examples include a stated mechanism of injury not consistent with a child's developmental age (e.g., a child who could not have rolled off a bed); and

[4] CA Penal Code 11165.7

15. On office visit, the presence of behavioral or emotional clues pointing toward possible abuse or neglect. These may include excessive hostility between a Member and his/her parent or caregiver; excessively avoidant, sullen, fearful, submissive, or anxious behaviors on the part of the Member; or sexually inappropriate, explicit, or familiar behavior on the part of the Member during the office visit.

Reporting Responsibilities and Time Frames

A. Whenever the Mandated Reporter, knows or reasonably suspects child abuse or neglect, the Mandated Reporter must make an initial report by telephone to the agency immediately or as soon as is practicably possible, and shall prepare and send, fax, or electronically transmit a written follow-up report within 36 hours of receiving the information concerning the incident.[5]

B. Mandated Reporters, will report known or suspected abuse or neglect such as:

   1. A minor who is physically injured by other than accidental means.
   2. A minor who is subjected to willful cruelty or unjustifiable punishment.
   3. A minor who is abused or exploited sexually.
   4. A minor who is neglected by a parent or caretaker who is unwilling to provide adequate food, clothing, shelter, medical care or supervision.

C. Mandated Reporters are responsible for telephoning reports of known or suspected child abuse or neglect and filing additional report(s) with appropriate agencies.

   1. The telephone report will include the following:
      a. Name, title, and daytime number of reporting party, agency name and address, and date of report.
      b. Name, address, age, and present location of minor.
      c. Any information that led the reporting party to suspect that abuse has occurred.
      d. Nature and extent of the minor's injury and condition, if known.
      e. The date and time of incident.
      f. Names and addresses of parents or legal guardians.
      g. Any other information requested by the child protective agency.

Riverside
Child Abuse:
Department of Public Social Services
Child Services Division
(800) 442-4918 (24 hours)

San Bernardino
Child Abuse:
Department of Public Social Services
Children and Family Services
(800) 827-8724 (24 hours)

[5] CA Penal Code, § 11166

Other Related Responsibilities

A. IEHP is responsible for educating their contracted PCPs of the procedures for reporting incidents of known or suspected abuse or neglect cases.

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5. MEDICAL CARE STANDARDS

N. Mandatory Domestic Violence Reporting

APPLIES TO:

A. This policy applies to all Mandated Reporters who treat or have contact with IEHP Covered Members.

POLICY:

A. Any Mandated Reporter who, in his or her professional capacity, or within the scope of his/her employment, has observed or has knowledge of an incident that reasonably appears to be abuse, is required by law to report directly to appropriate county agencies by telephone immediately or as soon as practicably possible.

B. Primary Care Providers (PCPs) are responsible for the overall health care of assigned Members including reporting incidents of known or suspected domestic violence cases.

C. PCPs and Health Care Providers who provide medical services are Mandated Reporters and as such they are responsible for directly informing the local law enforcement agency, within their respective county, of incidents of known or suspected domestic violence cases.[1]

DEFINITIONS:

A. Mandated Reporters, as it pertains to this policy, are health care Providers who are:

   1. Acting in their professional capacities or within the scope of their employment; and

   2. Provide medical services for a physical condition to a patient whom they know or reasonably suspect to have been abused.[2]

B. Domestic Violence: means abuse committed against an adult or a minor who is a spouse, former spouse, cohabitant, former cohabitant, or person with whom the suspect has had a child or is having or has had a dating or engagement relationship.[3]

PROCEDURES:

1. For the complete definition of "assaultive or abuse conduct," see CA Penal Code Section 11160(d). Behavioral Health (BH) professionals must comply with their own licensing board requirements regarding reporting domestic violence, which may be different from PCPs and other medical health care Providers.

Identification of domestic violence cases:

1. In an office visit, the presence of behavioral or emotional signs pointing toward possible domestic violence. These may include excessive hostility between a Member and his/her partner or spouse; excessively avoidant, sullen, fearful, submissive, or anxious behaviors on the part of the Member; and/or unexplained physical injuries that may be consistent

[1] California Penal Code § 11160
[2] Ibid.
[3] California Penal Code § 13700

with assault and battery.

Reporting Responsibilities and Time Frames

A. Mandated Reporters, who meet the criteria above, are responsible for telephoning reports of domestic violence with the appropriate law enforcement agency and filing an additional written report.[4]

1. The telephone report shall be made immediately or as soon as practically possible to the local law enforcement agency. The telephone report shall include the following:[5]

   a. Name, title, and daytime number of reporting party, agency name and address, and date of report.

   b. Name and present location of the injured person.

   c. The character and extent of the person's injuries.

   d. The identity of the person who allegedly inflicted the injury.

2. The written report will be faxed to the appropriate law enforcement agency within two (2) business days.[6] The report consists of the Suspicious Injury Report (Form CalEMA-920).[7]

Riverside	**San Bernardino**
Riverside Sheriff's Dept.	San Bernardino Sheriff's Dept.
(951) 955-2526 or Call 911	(909) 884-0156 or Call 911

Other Related Responsibilities

A. IEHP is responsible for educating their contracted PCPs of the procedures for reporting domestic violence cases.

B. If the Mandated Reporter suspects that minors were present during the domestic violence incident(s), a suspected child abuse report must be made. See Policy 5M, "Mandatory Child Abuse and Neglect Reporting."

[4] CA Penal Code § 11160
[5] Ibid.
[6] Ibid.
[7] https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/

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APPLIES TO:

A. This policy applies to all IEHP Covered Members.

POLICY:

A. All Providers who provide prenatal or postpartum care for a patient are required to offer to screen or appropriately screen a mother for maternal mental health conditions, both during pregnancy and postpartum.[1]

PURPOSE:

A. To promote early identification of behavioral health needs and provide coordination of behavioral health services for Members prenatally and up to two years postpartum.

DEFINITION:

A. Maternal mental health – Mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.[2]

PROCEDURES:

Identification of Members

A. IEHP Members to whom Providers must offer to screen or appropriately screen for maternal mental health conditions include Members who are pregnant, thinking of getting pregnant, or who have delivered in the past year. Additionally, this will include any women who has lost or terminated a pregnancy. For the most up to date information on screening tools and practices recommended by Postpartum Support International, refer to the following website at: https://www.postpartum.net/professionals/screening/.

B. All IEHP Members who are pregnant or are up to two years post-partum are eligible for this program.

   1. Members can self-refer by calling Member Services at (800) 440-4347.

   2. Providers can refer a Member by calling the Provider Call Center at (909) 890-2054 or emailing the Maternal Health Team at DGMMH@iehp.org, or by submitting a Care Management Referral Form, which is available online at www.iehp.org (see Attachment, "IEHP Care Management Referral Form found on the IEHP website).[3]

   3. IEHP Team Members may refer to the Behavioral Health and Care Management (BH & CM) Department Members identified with potential need for maternal mental health

[1] California Health and Safety Code (Health & Saf. Code), § 123640
[2] Ibid.
[3] https://www.iehp.org/en/providers/provider-resources?target=forms

services, who may be identified through health education programs and data analytics.

Program Enrollment

A. The BH & CM Maternal Mental Health Program takes a proactive approach in addressing disparities when dealing with maternal mental health by providing outreach calls to Members identified as potentially in need.

B. Members are offered care coordination, care management, and initial psychoeducation, which may include but is not limited to the following topics: importance of immunizations, post-partum appointments, and additional community services. Additionally, Members are screened and assessed for behavioral health services which may include individual therapy, psychiatry, and/or support groups. See Policy 7G, "Behavioral Health – Behavioral Health Services" for more information.

C. IEHP collaborates with external stakeholders and community partners to provide case management and/or care coordination to ensure these Members receive the high-quality care and services they need.

D. IEHP provides continued outreach and support as needed.

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