10. MEDICAL CARE STANDARDS

A. Initial Preventive Physical Exam

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. Primary Care Providers (PCPs) are expected to schedule and provide an Initial Preventive Physical Exam (IPPE) for all IEHP DualChoice Members within 12 months of the Member's enrollment.[1,2]

PROCEDURES:

A. An IPPE consists of the following components:[3]
   1. Review of comprehensive medical and social history;
   2. Review of risk factors for depression and other behavioral health conditions;
      a. Use of validated, evidence-based screening instrument recognized by national professional medical organizations. Examples include the PHQ-9 for depression screening and the GAD-7 for anxiety disorder screening.
   3. Review of functional ability and level of safety;
      a. Use of validated, evidence-based screening instrument recognized by national professional medical organizations to assess for hearing impairment, activities of daily living, fall risk and home safety. Examples include an audiogram for hearing impartment, the "Timed Up and Go Test" for assessment of fall risk, the Katz ADL Index, the Lawton-Brody I-ADL Scale, and the Westmead Home Safety Assessment.
   4. Examination - Obtain the following:
      a. Height, Weight, body mass index, and blood pressure;
      b. Visual acuity screen; and
      c. Other factors deemed appropriate based on the Member's medical and social history and current clinical standards.
   5. End of life planning (upon agreement with the Member);
      a. Verbal or written information provided to the Member about advanced directives.
   6. Review current opioid prescriptions (if it applies);
   7. Screen for potential substance abuse disorders (SUD);

[1] Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, Section 611
[2] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html
[3] Title 42, Code of Federal Regulations (CFR) § 410.16

8. Brief education, counseling, and referral to address any pertinent health issues identified during the first five (5) components of the exam; and
9. Brief education, counseling, and referral, with maintenance of a written plan regarding separate preventive care services covered by Medicare Part B.
    a. For Members 18 years of age or older, 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. Services with a grade "A" or "B" USPSTF designation are recommended to be offered or provided.[4]
    b. 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, "Recommended Immunizations for Adults" found on IEHP website[5]).[6]

B. Specific components of health assessments are also found in Policy 10B, "Adult Preventive Services."

C. PCPs must give each Member a written plan for obtaining the appropriate preventive services.

D. PCPs must maintain documentation of the IPPE in the Member medical record and maintained by the PCP office for a minimum of ten (10) years. The Member's chart must be maintained according to Policy 7A, "PCP and IPA Medical Record Requirements."

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[4] U.S. Preventive Services Task Force (USPSTF), https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
[5] https://www.iehp.org/en/providers/provider-resources?target=forms
[6] Centers for Disease Control and Prevention (CDC) – Recommended Adult Immunization Schedule: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule-bw.pdf

10. MEDICAL CARE STANDARDS

B. Adult Preventive Services

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) 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.[1] All preventive services with a grade of "A" or "B" must be offered or provided[2] and do not require prior authorization.

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.[3] When the Medi-Cal Provider Manual outlines immunization criteria less restrictive than ACIP criteria, Providers are to administer immunizations in accordance with the less restrictive Medi-Cal Provider Manual criteria.

PROCEDURES:

Health Assessments

A. PCPs are required to provide an Initial Preventive Physical Exam (IPPE) within 12 months of enrollment to all IEHP DualChoice Members assigned to them as outlined in Policy 10A, "Initial Preventive Physical Exam."[4,5]

B. PCPs are required to provide an Initial Health Assessment (IHA) within 120 calendar days of enrollment to all DualChoice Members assigned to them as outlined in Policy 10C, "Initial Health Assessment."

C. 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:[6]

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

[1] U.S. Preventive Services Task Force (USPSTF) http://www.uspreventiveservicestaskforce.org/BrowseRec/Index
[2] U.S. Preventive Services Task Force (USPSTF) A and B Recommendations http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
[3] Centers for Disease Control and Prevention (CDC) – Recommended Adult Immunization Schedule: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule-bw.pdf
[4] Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, Section 611
[5] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html
[6] Agency for Healthcare Research and Quality. Guide to Clinical Preventive Services, 2014. Web. June 2014. http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/index.html

2. Staying Healthy Assessment (SHA) using the age appropriate "Staying Healthy Assessment" tool as outlined in Policy 15G, "Individual Health Education Behavioral Assessment (IHEBA)/Staying Healthy Assessment (SHA);"
3. 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;
4. Dental screening – An oral survey for teeth, gum or oral cavity related illnesses or injuries; and
5. Vision and hearing screening as appropriate for age.

D. 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 120 calendar days of their enrollment. See Policy 10C, "Initial Health Assessment."

E. 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.

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 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.

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, "AUDIT-C" found on the IEHP website[7]);
   b. Brief Addiction Monitor (BAM) (See,"Brief Addiction Monitor (BAM) With Scoring & Clinical Guidelines" found on the IEHP website[8]);
   c. Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID);
   d. Tobacco Alcohol, Prescription Medications and other Substances (TAPS);

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

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.

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, "Brief Addiction Monitor (BAM) With Scoring & Clinical Guidelines" found on the IEHP website[9]);

   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:

   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

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

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.

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 and SHA 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:[10]
   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 Relations Team at (909) 890-2054 or accessed online through the IEHP website at https://www.iehp.org/en/providers/provider-resources?target=fsr-training:
      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 can 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 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.

[10] Agency for Healthcare Research and Quality. Guide to Clinical Preventive Services, 2014. Web. June 2014. http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/index.html

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, "Recommended Adult Immunization Schedule" found on the IEHP website[11]).[12]

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

[12] Centers for Disease Control and Prevention (CDC) – Recommended Adult Immunization Schedule: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule-bw.pdf

10. MEDICAL CARE STANDARDS

C. Initial Health Appointment

APPLIES TO:

A. This policy applies to IEHP DualChoice (HMO D-SNP) Members and Providers.

POLICY:

A. IEHP and its IPAs ensure that all new Members have an Initial Health Appointment (IHA) completed and periodically re-administered unless their Primary Care Provider (PCP) determines that the Member's medical record contains complete information, updated within the previous 12 months, consistent with the assessment requirements.

DEFINITION:

A. Initial Health Appointment (IHA) – Previously known as "Initial Health Assessment", the IHA is an assessment required to be completed within 120 calendar days of enrollment for new Members and must include the following: a history of the Member's physical and mental health; an identification of risks; an assessment of need for preventive screens or services; health education; and the diagnosis and plan for treatment of any diseases.

PROCEDURES:

Requirements for IHA Completion

A. An IHA:
   1. Must be performed by a Provider within the primary care medical setting;
   2. Is not necessary if the Member's PCP determines that the Member's medical record contains complete information that was updated within the previous 12 months;
   3. Must be provided in a way that is culturally and linguistically appropriate for the Member; and
   4. Must be documented in the Member's medical record.

B. IEHP Members are notified of the availability and need for their PCP to schedule and conduct the IHA within 120 calendar days of enrollment.[1]
   1. For Members ages 18 months and older, within 120 calendar days of enrollment.

Provider Responsibilities

A. PCPs should have specific policies and procedures in place to notify Members to come in for their IHA, timeline for its completion, and facilitate the Member's access to an IHA. PCPs may work in collaboration with their IPA to meet this requirement.
   1. PCP offices must maintain documentation of these notifications (i.e., outreach efforts and/or letters to all Members, active or not, informing them of the need for an IHA) for

[1] Ibid.

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 7A, "PCP and IPA 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.[2]

C. PCPs must ensure that a Member's completed IHA is documented in the Member's medical record and that appropriate assessments and referrals from the IHA are documented and available during subsequent 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 9B, "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 are guidelines and services, please see Policy 10B, "Adult Preventive Services."

Provider Training[3]

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:[4]

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] Ibid.
[3] DHCS PL 08-003
[4] Ibid.

2. For new plan Members who choose their current PCP as their new plan PCP, an IHA still needs to be completed within the timeframes described in this policy. 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 of the Member's enrollment with IEHP.
3. The Member was not continuously enrolled with IEHP for 120 days.
4. The Member was disenrolled from IEHP before an IHA could be performed.
5. The Member refuses an IHA.
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 all the required components. See Policy 6A, "Facility Site Review and Medical Record Review Survey Requirements and Monitoring."

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

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10. MEDICAL CARE STANDARDS

D. Obstetrical Services - PCP Role in Care of Pregnant Members

APPLIES TO:

A. This policy applies to all Primary Care Providers (PCPs) providing care to IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. Primary Care Providers (PCPs) are responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. PCPs are responsible for assessing whether a Member is pregnant, including the provision of pregnancy testing as appropriate.

PROCEDURES:

A. Once a Member is known to be pregnant, PCPs are responsible for determining whether the Member plans to continue the pregnancy or wishes to pursue a voluntary termination.

B. If the Member plans to continue the pregnancy, the PCP is responsible for referring the Member to an OB Practitioner, or giving the Member a choice of OB Practitioners, within the Member's IPA network. Otherwise, please see Policy 9D, "Access to Services with Special Arrangements" for information on termination of pregnancy.

C. For pregnant Members in prenatal care, PCPs are responsible for coordinating care with the OB Practitioner as necessary, including, but not limited to:
   1. Informing the OB Practitioner by phone or in writing of any significant medical conditions that may impact, or be impacted, by the pregnancy.
   2. Coordinating Member referrals with the OB Practitioner for any necessary specialty care needed for the Member; and
   3. Providing updates to the OB during the pregnancy of changes in the Member's medical status as needed.

D. PCPs cannot provide OB care for pregnant Members, unless specifically credentialed for OB privileges by IEHP and/or their IPA.
   1. All OB/GYN PCPs are credentialed for obstetrical services as part of the routine credentialing process unless they specifically request gynecologic privileges only.
   2. Family Practitioners wishing to provide obstetrical services must specifically request those privileges through IEHP or their IPA as outlined in Policy 5A1, "Credentialing Standards – Credentialing Policies."

10. MEDICAL CARE STANDARDS

D. Obstetrical Services - PCP Role in Care of Pregnant Members

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10. MEDICAL CARE STANDARDS

D. Obstetrical Services

1. Guidelines for Obstetrical Services

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) 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 IPA, or IEHP in scheduling an appointment for perinatal care.

B. IEHP and its IPAs must allow Members direct access, without referral, to a participating Provider that meets IEHP credentialing standards to provide OB/GYN services.[3] 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.

C. Referrals for high-risk OB conditions, health education, nutrition, or psychosocial services are

[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)

processed through the IPA's standard authorization process. Determinations must be made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Practitioners (See, "UM Timeliness Standards – IEHP DualChoice" found on the IEHP website[4][5] See Policy 14D, "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 48 hours of the request.[6] 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 IPA or IEHP's network. Please see Policy 10D2, "Obstetrical Services – Obstetric Care by Certified Nurse Midwives, Licensed Midwives, and Alternative Birthing Centers."

Perinatal Care

A. The content and timing of perinatal care should be varied according to the needs and risk status of the woman and her fetus. Typically, a woman 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. [7]

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:[8]

1. Family planning and pregnancy spacing (see Policy 10K, "Family Planning Services");
2. Immunization status (see Policy 10B, "Adult Preventive Services");
3. Risk factors for sexually transmitted infections (see Policy 10G, "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;

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

8. Family history;
9. Genetic history;
10. Nutrition, body weight, and exercise;
11. Teratogens, environmental and occupational exposures; and
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, "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 IEHP website[9].[10,11] 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.[12,13]

E. All Members must receive a prescription for prenatal vitamins as a standard of care.[14]

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.

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 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.

[9] https://www.iehp.org/en/providers/provider-resources?target=forms
[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] ACOG, Guidelines for Perinatal Care, https://www.acog.org/clinical
[13] 22 CCR § 51348(b)(2)
[14] 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. The ACOG recommends clinical interventions and strategies for pregnant Members who use tobacco.[15]
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 provide 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, "California Prenatal Screening Program" found on the IEHP website[16]). 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 of Health Care Services at (866) 718-7915.[17]

[15] The American Congress of Obstetricians and Gynecologists, "Committee Opinion Smoking Cessation During Pregnancy," Number 721, October 2017.
[16] https://www.iehp.org/en/providers?target=forms
[17] https://www.cdph.ca.gov/Programs/CFH/DGDS/CDPH%20Document%20Library/PNS%20Documents/PDCs_by_County.pdf

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 Member at their 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 IPA and Hospital/birth facility, coordinates referral of the newborn to the PCP within the mother's IPA 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 IPA'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, referral to a pediatric Practitioner for Well Child services and the Supplemental Food Program for Women, Infants and Children (WIC) program. Please see Policies 10E, "Referrals to the Supplemental Food Program for Women, Infants, and Children (WIC)" and 10K, "Family Planning Services."

IEHP and IPA 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 and its IPAs 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 IPA. 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.[18] Please see Policy 12A5, "Care Management Requirements – Continuity of Care" for more information.

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

D. The Member's IPA 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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[18] CA Health & Saf. Code § 1373.96

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D. Obstetrical Services

2. Obstetric Care by Certified Nurse Midwives, Licensed Midwives, and Freestanding Birthing Centers

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

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

DEFINITIONS:

A. Freestanding Birthing Center (FBC) – 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 and its IPAs 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 IPA 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 IPA or IEHP for consultation, high-risk referral, and delivery services, as needed.

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[1] California Health and Safety Code (Health & Saf. Code) § 1367.695(b)
[2] Department Health Care Services (DHCS) Policy Letter (PL) 12-003, "Obstetrical Care-Perinatal Services"
[3] Title 22, California Code of Regulations (CCR) § 51345

10. MEDICAL CARE STANDARDS

D. Obstetrical Services

3. PCP Provision of Obstetric Care

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) 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 a 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) Provider 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 28 weeks gestation including delivery (See "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 Medical Director or Chief Medical Officer. Further review may be completed by the Credentialing or Peer Review Subcommittee who will either approve or deny.

3. Facility Site Review. After submission of a request, 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, or not approving them with the reasons noted. Refer to Policy 6A, "Facility Site Review and Medical Records Review Survey Requirements and Monitoring" for more information.

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.iehp.org/en/providers?target=forms

decision. (See "IEHP Peer Review Level I and Credentialing Appeal" found on the IEHP website[2]).

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[2] https://www.iehp.org/en/providers?target=forms

10. MEDICAL CARE STANDARDS

E. Referrals to the Supplemental Food Program for Women, Infants and Children

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP and its IPAs, Primary Care Providers (PCP), Obstetrical (OB), and Pediatric Providers shall identify and refer eligible Members for Women, Infants and Children (WIC) services

PROCEDURES:

WIC Program

A. The WIC program provides nutrition assessment and education; breastfeeding promotion and support; electronic benefit transfer to meet dietary needs; and referrals to other needed health and social services. WIC works in connection with the participant's medical Practitioner and encourages ongoing and preventive care.

B. WIC participants must meet the following eligibility criteria:[1]

1. Income below 185% of the Federal Poverty Level; and
2. Pregnant person; or
3. Nursing a baby under one (1) year of age; or
4. Person who had a baby or was pregnant in the past six (6) months; or
5. A child up to their fifth birthday.

C. Members receive information regarding the availability of WIC Program services through the following methods:[2]

1. IEHP Member Handbook (upon health plan enrollment);
2. Providers;
3. IEHP Team Members; and
4. Health Plan Communications.

D. Providers must identify pregnant, breastfeeding, and postpartum women, as well as infants and children under the age of five (5) years, who would benefit from participating in the WIC program.

Referral

A. Each county WIC program can provide OBs, Pediatricians, and other PCPs with WIC

[1] https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/HowCanIGetWIC.aspx
[2] Title 42 Code of Federal Regulations (CFR) § 431.635(c)(2)

informational brochures, educational materials for Members, and PM 247 or CDPH 247A forms for their use when referring Members (See, "WIC Referral Forms" found on the IEHP website[3]).

B. OBs, Pediatricians, and other PCPs assist Members in applying for WIC by providing them with WIC agency phone numbers and the required documentation, including:

1. Height and weight;
2. Results of hemoglobin and hematocrit laboratory tests;
3. Estimated date of delivery;
4. Growth assessment for infants and children; and
5. Any identified nutritional risk factors such as gestational diabetes.

Such documentation can be provided to the Member for submission to WIC on the State approved WIC referral form (PM 247 or PM 247A), the physician's prescription pad, or other reporting forms commonly used by the PCP.

C. The referring Provider must document the WIC referral and relevant laboratory values in the Member's medical record.

D. If required, the referring Provider must provide additional laboratory test results or other data to the WIC program.

E. For any Member requiring a therapeutic formula, Providers must complete the WIC Pediatric Referral form (CDPH 247A) including Section 2. The Pediatric Referral form must include diagnosis, recommended formula/medical food, duration, and amount.

F. Members must apply for WIC services directly and meet eligibility requirements. IEHP Member Services is available to assist the Member, Provider, and IPA in locating the nearest WIC office or with making WIC appointments.

1. Riverside County - (800) 455-4942 or https://www.ruhealth.org/apply-4-wic
2. San Bernardino - (800) 472-2321 or https://wic.sbcounty.gov/doiqualify/
3. Out of County - (951) 360-8000

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

10. MEDICAL CARE STANDARDS

F. Sterilization Services

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. Sterilization is not a covered benefit under Medicare. Members that are IEHP DualChoice may be eligible for sterilization services through their IEHP Medi-Cal benefit.

B. IEHP ensures that obtaining and documenting informed consent for services, including sterilization, comply with State, Federal and contractual requirements.[1] See Policy 7C, "Informed Consent."

PROCEDURES:

A. Access to Sterilization Services

1. The IEHP DualChoice 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 IPA 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 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, "PM 330 Sterilization Consent Form

[1] Title 22, California Code of Regulations (CCR) § 51305.1 et seq.
[2] 22 CCR § 51305.1

– English" and "PM 330 Sterilization Consent Form – Spanish" found on 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 if performed or arranged solely to render the Member 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.[12]

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

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[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
[11] Ibid.
[12] Department of Health Care Services (DHCS) Medi-Cal Provider Manual, "Sterilization"

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

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G. Sexually Transmitted Infection Services

APPLIES TO:

A. A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP DualChoice 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. IEHP, its IPAs and 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, without examination of the Member's sexual partner or partners.[2]

C. IEHP DualChoice Members may make their own appointment with the STI services Practitioner of their choice. Members may call IEHP Member Services Department at (877) 273-4347 for assistance in accessing STI services. IEHP encourages Members to return to their PCPs to maintain continuity of care.

Access Within Network

A. Members may choose to receive STI services from any qualified Practitioner within the IEHP DualChoice network or their assigned IPA'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 Department at (877) 273-4347

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

for DualChoice 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. 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 services Practitioners adequate information for billing purposes. Practitioners must make such a form available to their Members (See "Authorization for Use and Disclosure of Personal Health Information – English" and "Authorization for Use and Disclosure of Personal Health Information – Spanish" found in IEHP website[5]), "Authorization for Use and Disclosure of Personal Health Information" forms can also be found on the IEHP website.

B. All Practitioners providing STI services are required by law to report individuals with certain communicable diseases to the Local Health Department (LHD). See Policy 10J, "Reporting Communicable Diseases to Public Health Authorities."

C. Medical records for Members presenting for STI evaluation must be maintained to protect the confidentiality of the Member. In-network Practitioners must adhere to IEHP Medical Records policies and procedures. See Policy 7A, "PCP and IPA 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 IEHP Direct or their IPA Case Management (CM) staff when Members have consented to release of information and require case management services due to their STI or medical condition complexity. IEHP or its IPA CM is then responsible for coordinating care including, but not limited to, referral to specialists and transfer of additional medical information.

Reimbursement

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

B. STI treatment Practitioners providing services to non-assigned Members within the IEHP DualChoice network will follow IEHP DualChoice reimbursement guidelines.

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

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G. Sexually Transmitted Infection Services

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10. MEDICAL CARE STANDARDS

H. HIV Testing and Counseling

APPLIES TO:

A. This policy applies to IEHP DualChoice (HMO D-SNP) 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 IPA's network or through a Local Health Department (LHD) and family planning providers.[2,3]

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).[4]

B. IEHP provides all IPAs and PCPs with an updated list of LHD operated or contracted HIV testing and counseling sites (See, "HIV Testing Sites – Riverside and San Bernardino" found on IEHP website[5].

C. IEHP contracts define HIV testing and counseling as an IPA 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.

B. The assessment performed by the PCP must align with the most up-to-date recommendations from the CDC.[6]

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[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] DHCS Policy Letter (PL) 97-08, "HIV Counseling and Testing Policy"

[3] California Health and Safety Code (Health & Saf. Code) § 1367.46

[4] CDC HIV Testing Guidelines: https://www.cdc.gov/hiv/guidelines/testing.html.

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

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

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. Either the 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 12A1, "Case Management Requirements – PCP Role."

E. 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 10K, "Family Planning Services";
2. As part of an STI visit at a LHD or other qualified Practitioner. See Policy 10G, "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, Counseling and Follow-up for Pregnant Members

A. IEHP and IPA 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:[7,8]

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.

[7] California Health and Safety Code (Health & Saf. Code), § 125107
[8] DHCS Policy Letter (PL) 97-08, "HIV Counseling and Testing Policy"

B. IEHP requires that all prenatal care Practitioners within its network and that of IPAs 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.[9,10]

C. All IEHP and IPA prenatal care Practitioners are required to discuss with the Member:[11]

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.[12]

Out-of-Network Reimbursement for Medicare 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.[13]

B. Out-of-network practitioners must submit claims to the Member's assigned IPA 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 and its IPAs 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. See Policy 16B4, "Provider (IPA, Hospital & Practitioner) Grievance and Appeals Resolution 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 states and federal regulations.[14] 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.[15]

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[9] DHCS Policy Letter (PL) 97-08, "HIV Counseling and Testing Policy"
[10] USPSTF, Screening for HIV Infection: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening
[11] DHCS PL 97-08
[12] Ibid.
[13] Ibid.
[14] CA Health & Saf. Code § 120975
[15] CA Health & Saf. Code § 120985

2. The Practitioner ordering the test may **not** disclose the results to IEHP, the Member's assigned IPA or any other health care service plan.[16,17]
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.[18] IEHP provides sample consent forms that may be used (See, "Consent for HIV Test – English" and "Consent for HIV Test – Spanish" in Section 10). 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,[19] all IEHP and IPA network Practitioners must obtain written consent from the Member to disclose HIV test results (See, "Authorization for Use and Disclosure of Personal health Information - English" and "Authorization for Use and Disclosure of Personal health Information – Spanish" found on the IEHP website[20]).

Reporting

A. All Practitioners are required to comply with state law and report all known AIDS cases to the Local Health Department. See Policy 10J, "Reporting Communicable Diseases to Public Health Authorities."

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Regulatory/ Accreditation Agencies:	☐ DHCS	☒ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2007	
Revision Effective Date:	January 1, 2023	

[16] CA Health & Saf. Code § 120985
[17] CA Health & Saf. Code § 121010
[18] CA Health & Saf. Code § 120990
[19] CA Health & Saf. Code § 12098
[20] https://www.iehp.org/en/providers/provider-resources?target=forms

10. MEDICAL CARE STANDARDS

I. Tuberculosis Services

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. Primary Care Providers (PCPs) must perform tuberculosis (TB) screening, diagnosis, treatment and follow-up as well as provide TB case 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 minimum during their initial health assessment. See Policy 10A, "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. Laboratories must report to the LHD testing results, including molecular and pathologic

[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

results, suggesting of diseases of public health importance. [7,8,9] See Policy 10J, "Reportable Communicable Diseases to Public Health Authorities."

Riverside County	(951) 358-5107
San Bernardino County	(800) 722-4794

3. Members who test positive and have no evidence of active TB, must be evaluated for TB preventive therapy and treated, if appropriate, per CDC guidelines.

C. Public Health Reporting

1. Providers must report all confirmed (TB3) or highly suspected (TB5) active TB cases to the LHD in the county where the Member resides.[10] See Policy 10J, "Reporting Communicable Diseases to Public Health Authorities" for reporting guidelines.

Riverside County	(951) 358-5107
San Bernardino County	(800) 722-4794

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.[11]

3. PCPs must cooperate with LHD in conducting contact tracing and outbreak investigations potentially involving Members, as well as for any request for medical records, screening, diagnostic work-up, and any other pertinent clinical or administrative information. [12,13]

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. [14,15]

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)

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:

[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] Title 17 California Code of Regulations (CCR) § 2500.
[11] California Health and Safety Code (Health & Saf. Code) § 121361.
[12] MOU between IEHP and RUHS, Public Health Services, 06/01/14
[13] MOU between IEHP and SBDPH, Health Services for Medi-Cal Members, 07/01/07
[14] MOU between IEHP and RUHS, Public Health Services, 06/01/14
[15] MOU between IEHP and SBDPH, Health Services for Medi-Cal Members, 07/01/07

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 PCPs 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 and IPA Responsibilities

A. IEHP and its IPAs provide monitoring and case management for all suspected and active TB cases. IEHP and IPA CM provide the coordination of TB care with the LHD. See policies 25C1, "Care Management Requirements –IEHP Monitoring and Oversight," and 25C1, "Care Management Requirements – IPA Responsibilities."

B. IEHP and its IPAs continue 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.

10. MEDICAL CARE STANDARDS

I. Tuberculosis Services

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Regulatory/ Accreditation Agencies:	☐ DHCS	☒ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2007	
Revision Effective Date:	January 1, 2023	

10. MEDICAL CARE STANDARDS

J. Reporting Communicable Diseases to Public Health Authorities

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) 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, "Reportable Diseases and Conditions – Riverside" and "Reportable Diseases and Conditions – San Bernardino" found on 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, "Reportable Diseases and Conditions – Riverside" and "Reportable Diseases and Conditions – San Bernardino" found in 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, "Reportable Diseases and Conditions – Riverside" and "Reportable Diseases and Conditions – San Bernardino" found on 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

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

Control Agency or Humane Society. The County Animal Control office may assist in filing 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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Regulatory/ Accreditation Agencies:	☐ DHCS	☒ CMS
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10. MEDICAL CARE STANDARDS

K. Family Planning Services

***APPLIES TO*:**

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. IEHP DualChoice Members have the right to access, without prior authorization, any qualified family planning Practitioner within or outside of the IEHP or the Member's IPA'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 IPA's responsibility. This responsibility includes payment for services accessed by IEHP DualChoice Members at any qualified family planning Practitioner. IEHP is responsible for the facility charges resulting from qualifying inpatient family planning services.

B. The following services may be provided to IEHP DualChoice 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 listed under the IEHP Formulary;
8. Tubal ligation;
9. Vasectomy; and
10. Pregnancy testing and counseling.

C. IEHP will cover up to a 12 month supply of 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.

D. 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.

E. 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. IEHP DualChoice 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. A sample informed consent for contraceptive methods other than sterilization is attached (See, "Contraceptive Informed Choice Form – English" and "Contraceptive Informed Choice Form – Spanish" found on IEHP website[1]. 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.[2]

Accessing Family Planning Services

A. IEHP DualChoice 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. 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.

C. 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, "Authorization or Refusal to Release Medical Record – Out-of-Network Family Planning – English" and "Authorization or Refusal to Release Medical Record – Out-of-Network Family Planning – Spanish" found on IEHP website[3].

D. 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 IPA. Practitioners must make such a form available to Members. A sample form in both English and Spanish is attached (See, "Authorization for Use and Disclosure of Personal Health Information – English" and "Authorization for Use and Disclosure of Personal Health Information – Spanish" found on the IEHP website[4]).

Coordination of Care

A. Listed below are the roles and responsibilities of the PCP, out-of-network family planning Practitioner, the Member's IPA and IEHP staff in coordinating care for IEHP DualChoice

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

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 IPA 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 IPA 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 IPA CM to coordinate care.

Out-of-Network Family Planning Services Reimbursement

A. Family planning services, including related STI and HIV counseling, 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 IPA 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 and its IPAs 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 Grievance Process. See Policy 16B4, "Grievance and Appeal Resolution Process for Providers - IPA, Hospital, and Practitioner."

10. MEDICAL CARE STANDARDS

K. Family Planning Services

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☒ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2011	
Revision Effective Date:	January 1, 2023	

10. 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 DualChoice (HMO D-SNP) 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 directly inform appropriate county agencies by telephone immediately or as soon as practicably possible. An additional written report shall also be submitted to the appropriate agencies within two (2) working days.[1]

B. Mandated Reporters include, but are not limited to Primary Care Providers (PCPs), Specialists, nurses, and IEHP professional staff (i.e. Providers, care managers, and UM personnel), who treat and/or provide assistance in the delivery of health care services to IEHP Members.

C. **Exceptions**: Physicians and Surgeons, Registered Nurses, and Psychotherapists are NOT required to report incidents of Elder/Dependent Adult Abuse when **all** the following exist:[2]

1. The Mandated Reporter has been informed by an Elder/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/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 a 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,

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

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 an Elder 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 an 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 an Elder or a 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's 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, 59 years or older.[4]

D. **Mandated Reporter** – an individual who is required by law to report identified or suspected Elder/Dependent Adult abuse. Such individuals include any person who has assumed full or intermittent responsibility for care or custody of an Elder or Dependent Adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for Elder or Dependent Adults, or any Elder or Dependent Adult care custodian, health Providers, clergy member, or employee of a county adult protective services agency or a local law enforcement agency.

[3] CA Welf. & Inst. Code § 15750(b)(1)(A)
[4] CA Welf. & Inst. Code § 15750(b)(2)

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

F. **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.

PROCEDURES:

Identification of Suspected Abuse

A. Health Care Providers and caregivers must be alert for signs of possible Elder/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/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 Member's stated history, or inconsistent with the caregiver's history. Examples include a stated mechanism of injury not consistent with an Elder/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 Member and his/her caregiver; excessively avoidant, sullen, fearful, submissive, or anxious behaviors on the part of the Member.

B. In addition, Mandated Reporters have a variety of further information sources for the identification of Elder/Dependent Adult Abuse cases, including the following (when access to such information is available to the Mandated Reporter, and not otherwise prohibited by state or federal law):

1. Request by an Emergency Room for authorization to treat an illness or injury of suspicious or questionable nature;
2. Request by an Urgent Care Center for authorization to treat an illness or injury of suspicious or questionable nature;
3. Hospitalization of a Member for suspicious trauma, illness, or injury;
4. Office visits with PCPs, and other health care Providers that reveal unusual physical or emotional findings;
5. Abuse cases identified during the UM or CM process;
6. Requests for assistance received by Member Services from victims of Abuse; and/or
7. Calls to the 24-Hour Nurse Advice Line from potential victims of Abuse.

C. 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 of Suspected Abuse

A. **Suspected or Alleged Physical Abuse in a Long-Term Care 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:
   a. A telephone report shall be made to the local law enforcement agency within two (2) hours of the Mandated Reporter identifying/suspecting the Physical Abuse; and
   b. A written report shall be made to the local Ombudsman, the corresponding licensing agency, and the local law enforcement agency within two (2) hours of the Mandated Reporter identifying/suspecting the 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 24 hours of the Mandated Reporter identifying/suspecting the Physical Abuse; and
   b. A written report shall be made to the local Ombudsman, the corresponding licensing agency, and the local law enforcement agency within 24 hours of the Mandated Reporter identifying/suspecting the Physical Abuse.
4. If the suspected Physical Abuse is allegedly caused by a resident of the long term care facility who is diagnosed with dementia, and there is no Serious Bodily Injury, the Mandated Reporter shall report to the local Ombudsman or law enforcement agency by

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

telephone, immediately or as soon as practicably possible, and by written report, within 24 hours.

B. **Suspected or Alleged 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 long-term care facility but **not** a state mental health hospital or a state development center.
2. If the suspected or alleged Abuse is other than Physical Abuse, a telephone report and a written report shall be made to the local Ombudsman or the local law enforcement agency immediately or as soon as practicably possible. The written report shall be submitted within two (2) working days.

C. **Suspected or Alleged Abuse in a State Mental Hospital or a State Development Center**[7]

1. If the suspected or alleged Abuse resulted in any of the following incidents, a report shall be made immediately, no later than two (2) hours, by the Mandated Reporter identifying/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.
   b. A sexual assault, as defined in CA Welfare & Institutions Code § 15610.63.
   c. An assault with a deadly weapon[8] by a nonresident of the state mental hospital or state development center.
   d. An assault with force likely to produce great bodily injury.[9]
   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 identifying/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 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.

[6] CA Welf. & Inst. Code § 15630(b(1)(B)
[7] CA Welf. & Inst. Code § 15630(b)(1)€
[8] CA Penal Code § 245
[9] Ibid.

D. **Abuse Outside of a Long-Term Care Facility, State Mental Hospital, or a State Development Center**[10]

1. If the Abuse has occurred in any place other than a long-term care 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.[11]

F. **Information to Include in Abuse Reports**

1. The report shall include the following, if known:[12]
   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 the Elder/Dependent Adult.
   c. Any information that led the reporting party to suspect that Abuse has occurred.
   d. Nature and extent of the Elder/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/Dependent Adult's care.
   g. Any other information requested by the adult protective agency.

Riverside	**San Bernardino**
Dependent Adult and Elder Abuse: Adult Services Division (800) 491-7123 (24 hours)	Dependent Adult and Elder Abuse: Department of Aging and Adult Services (877) 565-2020 (24 hours)

[10] CA Welf. & Inst. Code § 15630
[11] CA Penal Code § 11161.8
[12] CA Welf. & Inst. Code § 15630

10. MEDICAL CARE STANDARDS

L. Mandatory Elder or Dependent Adult Abuse Reporting

Other Related Responsibilities

A. IEHP and its IPAs are responsible for educating their contracted PCPs and Specialists of the procedures for reporting Abuse cases.

B. IEHP and its IPAs are responsible for case managing abuse cases and verifying that reporting has occurred.

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10. MEDICAL CARE STANDARDS

M. Mandatory Domestic Violence Reporting

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. Primary Care Providers (PCPs) are responsible for the overall health care of assigned Members including the identification and reporting of domestic violence cases.

B. 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 identified domestic violence cases. [1]

C. Mandated Reporters 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]

D. Mandated Reporters will immediately make a report when they identify:[3]

   1. Any person suffering from or whose death is caused by any wound or other physical injury inflicted by his or her own act or inflicted by another where the injury is by means of a firearm.
   2. Any person suffering from or whose death is caused by any wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct, including, but not limited to, the following:
      a. Torture;
      b. Assault or battery (unwelcome physical contact); and
      c. Sexual battery, rape including spousal rape.
   3. 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.

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

PROCEDURES:

Identification of domestic violence cases

A. At the health plan level, Providers, care managers, and UM personnel are able to identify and report incidents of domestic violence. Any obligation to investigate the particulars of any case rests with law enforcement.

   1. On office visit, the presence of behavioral or emotional clues 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 physical injuries that are consistent with assault and battery.

   2. Mandated Reporters within IEHP have a variety of information sources for the identification of domestic violence cases including the following:

      a. Domestic violence cases identified during the utilization management or care management process;

      b. Requests for assistance received by Member Services from victims of domestic violence;

      c. Calls to the 24-Hour Nurse Advice Line from victims of domestic violence.

Reporting Domestic Violence Cases

A. Mandated Reporters 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 2-920 Mandated Suspicious Injury Report)[7].

[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/

10. MEDICAL CARE STANDARDS

M. Mandatory Domestic Violence Reporting

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 and its IPAs are responsible for educating their contracted PCPs of the procedures for reporting domestic violence cases.

B. IEHP and its IPAs are responsible for case managing domestic violence cases and verifying that reporting has occurred.

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10. Medical Care Standards

N. Maternal Mental Health Program

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) 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 and up to two years postpartum 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 have lost or terminated a pregnancy. For the most up to date information on screening tools and practices recommended by Postpartum Support International (PSI), 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 (877) 273-4347.

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

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

10. Medical Care Standards

N. Maternal Mental Health Program

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 education on how to enroll newborn(s) for Medi-Cal. Additionally, Members are screened for behavioral health services and connected to the appropriate level of care which may include individual therapy, psychiatry, and/or support groups. See Policy 12BK1, "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.

D. IEHP also may link the member to community resources and county agency services. IEHP provides continued outreach and support as needed.

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	☐ DMHC	☐ NCQA
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10. MEDICAL CARE STANDARDS

O. Vision Examination Level Standards

APPLIES TO:

A. This policy applies to IEHP DualChoice (HMO D-SNP) 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. **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.

B. 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. IEHP-credentialed Ophthalmology Providers should continue to work through their contracted IPA to provide these services.

C. 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, please see Policy 12G, "Vision Services."

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	☐ DMHC	☐ NCQA
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10. MEDICAL CARE STANDARDS

P. Community Health Worker Services

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

POLICY:

A. Community Health Worker (CHW) services for IEHP DualChoice Members are covered as a Medi-Cal benefit. IEHP covers CHW services as preventive services and on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law. The Recommending Provider must determine whether a Member meets eligibility criteria for CHW services, as described in this policy, prior to submitting a written recommendation.

B. CHW services are considered medically necessary for Members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma; who are at risk for a chronic health condition or environmental health exposure; who face barriers in meeting their health or health-related social needs; and/or who would benefit from preventive services.

PURPOSE:

A. To provide guidance regarding the qualifications for becoming a CHW, the definitions of eligible populations for CHW services, and descriptions of applicable conditions for the CHW benefit.

DEFINITION:

A. Community Health Worker (CHW) Services – These services are preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health.[1,2]

B. Plan of Care – A written document that is developed by one or more licensed Providers to describe the supports and services a CHW will provide to address ongoing needs of a Member.[3]

C. Supervising Provider – The organization or individual contracted with IEHP to employ or otherwise oversee the CHW. The Supervising Provider can be a licensed Provider, a hospital, an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization (CBO).[4]

D. Recommending Provider - A physician or other licensed practitioner of the healing arts that

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 22-016, "Community Health Worker Services Benefit"
[2] DHCS Medi-Cal Provider Manual, "Community Health Worker (CHW) Preventive Services"
[3] Ibid.
[4] Ibid.

recommends CHW services within their scope of practice under state law. Other licensed practitioners who can recommend CHW services within their scope of practice include physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists.[5]

PROCEDURES:

Community Health Worker Services & Requirements

A. Covered CHW Services, including Violence Prevention Services – Services can be provided as individual or group sessions, and may be provided virtually or in-person with locations in any setting including, but not limited to, outpatient clinics, hospitals, homes, or community settings, and without any service location limits. These covered services do not include any service that requires a license:[6]

1. Health Education – Promoting a Member's health or addressing barriers to physical and mental health care. Health Education content must be consistent with established or recognized health care standards and may include coaching and goal setting to improve a Member's health or ability to self-manage their health conditions.
2. Health Navigation – Providing information, training, referrals, or support to assist Members to access health care, understand the health care delivery system, or engage in their own care.
3. Screening and Assessment – Providing screening and assessment services that do not require a license, and assisting a Member with connecting to appropriate services to improve their health.
4. Individual Support or Advocacy – Assisting a Member in preventing the onset or exacerbation of a health condition, or preventing injury or violence.

Services may be provided to a parent or legal guardian of a Member under age 21 for the direct benefit of the Member, in accordance with a recommendation from a licensed Provider. A service for the direct benefit of the Member must be billed under the Member's Medi-Cal ID.

B. CHWs may provide CHW services to individuals with asthma, but evidence-based asthma self-management education and asthma trigger assessments may only be provided by asthma preventive service providers, who have completed either a certificate from the California Department of Public Health Asthma Management Academy, or a certificate demonstrating completion of a training program consistent with the guidelines of the National Institutes of

[5] DHCS APL 22-016
[6] Ibid.

Health's Guidelines for the Diagnosis and Management of Asthma.[7]

C. Non-covered CHW services include:[8]

1. Clinical case management/care management that requires a license;
2. Child care;
3. Chore services, including shopping and cooking meals;
4. Companion services;
5. Employment services
6. Helping a Member enroll in government or other assistance programs that are not related to improving their health as part of a plan of care;
7. Delivery of medication, medical equipment, or medical supply;
8. Personal Care services/homemaker services;
9. Respite care;
10. Services that duplicate another covered Medi-Cal service already being provided to a Member;
11. Socialization;
12. Coordinating and assisting with transportation
13. Services provided to individuals not enrolled in Medi-Cal, except as noted above; and
14. Services that require a license.

Although CHWs may provide CHW services to Members with mental health and/or substance use disorders, CHW services do not include Peer Support Services as covered under the Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and Specialty Mental Health Services programs. CHW services are distinct and separate from Peer Support Services.[9]

D. As preventive health services, CHW services do not require prior authorization for the first 12 units;[10] however, CHW services require a written recommendation submitted to the Member's IPA by the Recommending Provider. IEHP and its IPAs must not establish unreasonable or arbitrary barriers for accessing coverage. Quantity limits may however, be applied based on goals detailed in the plan of care.[11]

E. For Members who need multiple ongoing CHW services or continued CHW services after 12 units of service, a written plan of care must be written by one or more individual licensed Providers, which may include the Recommending Provider and other licensed Providers

[7] DHCS APL 22-016
[8] Ibid.
[9] Ibid.
[10] Ibid.
[11] Ibid.

affiliated with the Supervising Provider.[12]

1. The Provider ordering the plan of care does not need to be the same Provider who initially recommended CHW services or the Supervising Provider for CHW services.
2. The CHW may participate in the development of the plan of care, and may take a lead role in drafting the plan of care if done in collaboration with the Member's care team and/or other Providers referenced in this policy.
3. The plan of care may not exceed a period of one year and must:
    a. Specify the condition that the service is being ordered for and be relevant to the condition;
    b. Include a list of other health care professionals providing treatment for the condition or barrier;
    c. Contain written objectives that specifically address the recipient's condition or barrier affecting their health;
    d. List the specific services required for meeting the written objectives; and
    e. Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the plan's objectives.
4. A licensed Provider must review the Member's plan of care every six (6) months from the effective date of the initial plan of care, and determine if progress is being made toward the written objective and whether services are still medically necessary.
5. If there is a significant change in the Member's condition, Providers should consider amending the plan for continuing care or discontinuing services if the objectives have been made.

Member Eligibility

A. The Recommending Provider must determine whether a Member meets eligibility criteria for CHW services based on the presence of one or more of the following:[13]
    1. Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed;
    2. Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition;
    3. Any stressful life event presented via the Adverse Childhood Events screening;
    4. Presence of known risk factors, including domestic or intimate partner violence, tobacco

[12] DHCS APL 22-016
[13] Ibid.

use, excessive alcohol use, and/or drug misuse;

5. Results of a SDOH screening indicating unmet health-related social needs, such as housing or food insecurity;
6. One or more visits to a hospital emergency department (ED) within the previous six months;
7. One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization;
8. One or more stays at a detox facility within the previous year;
9. Two or more missed medical appointments within the previous six months;
10. Member expressed need for support in health system navigation or resource coordination services; and/or
11. Need for recommended preventive services, including updated immunizations, annual dental visit, and well childcare visits for children.

B. CHW violence prevention services are specific to community violence (e.g., gang violence) and are available to Members who meet any of the following circumstances, as determined by a licensed practitioner:[14]

1. The Member has been violently injured as a result of community violence.
2. The Member is at significant risk of experiencing violent injury as a result of community violence.
3. The Member has experienced chronic exposure to community violence.

CHW services can be provided to Members for interpersonal/domestic violence through the other pathways with training and experience specific to these needs.

C. IEHP uses data driven approaches to determine and understand priority populations eligible for CHW services, including but not limited to, using past and current utilization and encounter data, frequent hospital admissions or emergency department visits, demographic or social determinants of health data, referrals from the community, and needs assessments, etc.[15]

D. IEHP attempts to outreach to qualifying Members and their Providers to encourage utilization of CHW services. IEHP encourages its Providers to communicate with Members about the availability of these services.[16]

Community Health Worker Qualifications & Responsibilities

A. CHWs must have lived experience that aligns with and provides a connection between the CHW and the Member or population being served. This may include, but is not limited to,

[14] DHCS APL 22-016
[15] Ibid.
[16] Ibid.

experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one or more linguistic, cultural, or other groups in the community for which the CHW is providing services. [17]

B. Supervising Providers maintain evidence of minimum qualifications through one of the following pathways, as determined by the Supervising Provider: [18]

1. Certificate Pathway – CHWs demonstrating qualifications through this pathway must provide proof of completion of CHW certificate and/or Violence Prevention Professional Certificate.[19]

2. Work Experience Pathway – An individual who has at least 2,000 hours working as a CHW in paid or volunteer hours within the previous three years and has demonstrated skills in practical training in the areas described in DHCS APL 22-016, as determined and validated by the Supervising Provider, may provide CHW services without a certificate of completion for a maximum period of 18 months. A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a Member.

C. CHWs must complete a minimum of six (6) hours of additional relevant training annually. The Supervising Provider must maintain evidence of this training and may provide and/or require additional training, as identified by the Supervising Provider. [20]

D. CHW Documentation Requirements[21]

1. Documentation must include the dates and time/duration of services provided to Members and should also reflect information on the nature of the service provided and support the length of time spent with the patient that day.

2. Documentation should be integrated into the Member's medical record and available for encounter data reporting.

3. Documentation must be made accessible to the Supervising Provider upon their request.

Supervising Provider Responsibilities

A. The Supervising Provider is responsible for the following,[22] as descried in DHCS APL 22-016 or most current version and this policy:

[17] DHCS APL 22-016
[18] Ibid.
[19] Ibid.
[20] Ibid.
[21] Ibid.
[22] Ibid.

1. Ensuring that CHWs meet the minimum qualifications set forth in DHCS APL 22-016;
2. Maintaining evidence of required lived experience, minimum qualifications, and completion of training;
3. Overseeing CHWs and the services delivered to IEHP Members;
4. Submitting claims for services provided by CHWs.

B. The Supervising Provider does not need to be the same entity as the Provider who made the referral for CHW services, and do not need to be physically present at the location when CHWs provide services to Members. Management and day-to-day supervision of CHWs as employees may be delegated as determined by the Supervising Provider. However, the Supervising Provider is responsible for ensuring the provision of CHW services complies with all applicable requirements. [23]

1. Direct oversight of CHWs includes, but is not limited to, guiding CHWs in providing services, participating in the development of a plan of care, and following up on the progression of CHW services to ensure that services are provided in compliance with all applicable requirements.
2. Indirect oversight of CHWs includes, but is not limited to, ensuring connectivity of CHWs with the ordering entity and ensuring appropriate services are provided in compliance with all applicable requirements.

C. Supervising Providers must not bill for CHW services that are duplicative to Enhanced Care Management (ECM) services for the same member for the same time period. [24] For Providers' reference, IEHP's secure Provider portal identifies Members that are enrolled in the ECM program.

Recommending Provider Responsibilities

A. The Recommending Provider is responsible for: [25]

1. Determining whether a Member meets eligibility criteria for CHW services based on the eligibility criteria described in this policy;
2. Submitting a written recommendation to IEHP ; and
3. Submitting to IEHP for authorization if ongoing CHW services are needed after the first 12 units.

IEHP and IPA Responsibilities

A. IEHP ensures that network Providers that will operate as Supervising Providers, are enrolled as Medi-Cal Providers if there is a state-level enrollment pathway for them to do so. [26] Please

[23] DHCS APL 22-016
[24] Ibid.
[25] Ibid.
[26] Ibid.

see Policy 5C, "Provider Screening and Enrollment Requirements.

B. Supervising Providers that do not have a state-level enrollment pathway are not required to enroll in the Medi-Cal program. They are instead vetted against criteria including but are not limited to the following to ensure that they can meet the standards and capabilities required to be a Supervising Provider: [27]

1. Sufficient experience providing similar services within the service area;
2. Ability to submit claims or invoices using standardized protocols;
3. Business licensing that meets industry standards;
4. Capability to comply with all reporting and oversight requirements;
5. History of fraud, waste, and/or abuse;
6. Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and
7. History of liability claims against the Provider.

C. IEHP ensures that Supervising Providers or their subcontractors contracting with or employing CHWs to provide covered CHW services to IEHP Members verify that CHWs have sufficient experience to provide services, as well as adequate supervision and training. [28]

D. IEHP must ensure that CHW services are not duplicative to services that are reimbursed through other benefits such as Enhanced Care Management (ECM), which is inclusive of the services within the CHW benefit. [29]

E. IEHP must reimburse CHW services through the Supervising Provider and as outlined in the DHCS Medi-Cal Provider Manual. [30] Tribal clinics may bill IEHP for CHW services at the Fee-for-Service rates using the same Current Procedural Terminology (CPT) codes.[31] See Policy 20A, "Claims Processing" for more information.

F. IEHP will ensure and monitor sufficient Provider networks within the service area, including for CHW services.

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[27] DHCS APL 22-016
[28] Ibid.
[29] Ibid.
[30] DHCS Medi-Cal Provider Manual, "Community Health Worker (CHW) Preventive Services"
[31] DHCS APL 22-016