10. MEDICAL CARE STANDARDS

A. Initial Health Appointment

APPLIES TO:

A. This policy applies to IEHP Medi-Cal 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.[1]

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.[2,3,4]

PROCEDURES:

Requirements for IHA Completion

A. An IHA:[5]

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.

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 22-030 Supersedes APL 13-017 and Policy Letters 13-001 and 08-003, "Initial Health Appointment"
[2] DHCS CalAIM: Population Health Management (PHM) Policy Guide
[3] Title 22 California Code of Regulations § 53851(b)(1)
[4] DHCS APL 22-030
[5] Ibid.

B. IEHP Members are notified of the availability and need for their PCP to schedule and conduct the IHA within these timeframes:[6]

1. For Members less than 18 months of age, within 120 calendar days of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures, whichever is sooner;[7] or
2. 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, timelines 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 a minimum of ten (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.

C. PCPs must ensure that a Member's completed IHA is documented in their 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.[8] For information on age-specific preventive care guidelines and services, please see Policies 10B, "Adult Preventive Services," 10C1, "Pediatric Preventive Services – Well Child Visits," and 10C2, "Pediatric Preventive Services – Immunization Services."

Provider Training

[6] DHCS CalAIM: PHM Policy Guide
[7] https://www.aap.org/en/practice-management/bright-futures
[8] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.3, Initial Health Appointment

10. MEDICAL CARE STANDARDS

A. Initial Health Appointment

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

1. Adequate documentation of IHAs or the reasons IHAs were not completed;
2. Timelines for performing IHAs; and
3. Procedures to assure that visit(s) for the IHA are scheduled and that Members are contacted about missed IHA appointments.

Exceptions from IHA Requirements

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

1. All elements of the IHA were completed within 12 months prior to the Member's enrollment with IEHP. If the PCP did not perform the IHA, he or she must document in the Member's medical record that the findings have been reviewed and updated accordingly.
2. For new plan Members who choose their current PCP as their new plan PCP, an IHA still needs to be completed within 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 months of the Member's enrollment with IEHP.
3. The Member was not continuously enrolled with IEHP for 120 calendar days.
4. The Member was disenrolled from IEHP before an IHA could be performed.
5. The Member, including emancipated minors or a Member's parent(s) or guardian, refuses an IHA (See Attachment 6, "DHCS MMCD Medical Record Review Standards" found on the IEHP website).[9]
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.[10]

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.

[9] https://www.iehp.org/en/providers/provider-resources?target=forms
[10] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.3, Initial Health Appointment

10. MEDICAL CARE STANDARDS

A. Initial Health Appointment

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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10. MEDICAL CARE STANDARDS

B. Adult Preventive Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal 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.[1,2] All preventive services with a grade of "A" or "B" must be offered or provided and do not require prior authorization.[3,4,5]

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. 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.[6]

DEFINITION:

A. Adverse Childhood Experience (ACE) – For the purpose of this policy, this is defined as events, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.[7]

PROCEDURES:

Initial Health Appointments

A. IEHP and its IPAs ensure that all 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. For Members ages 18

[1] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.5, Services for Adults
[2] U.S. Preventive Services Task Force (USPSTF) http://www.uspreventiveservicestaskforce.org/BrowseRec/Index
[3] U.S. Preventive Services Task Force (USPSTF) A and B Recommendations http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations
[4] California Health and Safety (Health & Saf.) Code § 1367.002(a)(1)
[5] Department of Managed Health Care (DMHC) All Plan Letter (APL) 23-009, "Health Plan Coverage of Preventive Services"
[6] DHCS APL 18-004 Supersedes Policy Letter (PL) 96-013 and APL 07-015, "Immunization Requirements"
[7] Ca. Health & Saf. Code § 1367.34(b)

and older, the IHA must be completed within one hundred twenty (120) calendar days of their enrollment.[8,9,10] See Policy 10A, "Initial Health Appointment," for more information.

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

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

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

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

Adverse Childhood Experience (ACE) Screening

A. ACE screenings in all inpatient and outpatient settings are only reimbursable for contracted Providers who complete the certified core ACEs Aware online training and who self-attest that they have completed this training; and have used the ACE Questionnaire for Adults, which can be found in various languages at: https://www.acesaware.org/learn-about-screening/screening-tools/screening-tools-additional-languages/.[11]

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

1. The screening tool that was used;
2. That the completed screen was reviewed;
3. The results of the screen;

[8] DHCS APL 22-030, "Initial Health Appointment"
[9] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.5, Services for Adults
[10] DHCS CalAIM: Population Health Management (PHM) Policy Guide, Chapter II, Section C, Provision 2, Streamlining the Initial Screening Process
[11] DHCS Medi-Cal Provider Manual, "Evaluation and Management"

4. The interpretation of results; and
5. What was discussed with the Member and/or family, and any appropriate actions taken.

C. Applicable billing codes and frequency limits for Members under age 21 and ages 21 through 64 are outlined in the DHCS Medi-Cal Provider Manual, "Evaluation and Management."

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

A. SABIRT services may be provided by Providers in a primary care setting and within their scope of practice, including, but not limited to, physicians, physician assistants, nurse practitioners, certified nurse midwives, licensed midwives, licensed clinical social workers, licensed professional clinical counselors, psychologists and licensed marriage and family therapists.[12] Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.[13]

B. PCPs, within their scope of practice, must provide SABIRT services for Members 11 years of age and older, including pregnant women as follows:[14]

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

   Please see Policy 10C1, "Pediatric Prevention Services – Well Child Visits" for a list of validated tools for adolescents.

2. When the Member's screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or substance use disorder is present. Validated alcohol

[12] DHCS APL 21-014 Supersedes APL 18-014, "Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment"
[13] Ibid.
[14] Ibid.

and drug assessment tools include, but are not limited to:[15]

a. Alcohol Use Disorders Identification Test (AUDIT);

b. Brief Addiction Monitor (BAM) ;

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:[16]

   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:[17]

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

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

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

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

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

C. IEHP informs Members of SABIRT services through Member-informing materials, including

[15] DHCS APL 21-014
[16] Ibid.
[17] Ibid.

but not limited to the Evidence of Coverage (EOC).[18]

D. When a Member transfers from one PCP to another, the receiving PCP must attempt to obtain the Member's prior medical records, including those pertaining to the provision of preventive services.[19]

E. IEHP complies with all applicable laws and regulations relating to the privacy of substance use disorder records. Refer to Policy 7B, "Information Disclosure and Confidentiality of Medical Records," for more information.

Annual Cognitive Health Assessment[20]

A. The annual cognitive health assessment (CHA) is for Medi-Cal Members who are 65 years of age or older and who do not have Medicare coverage. This is an initial assessment intended to identify whether the Member has signs of Alzheimer's diseases or related dementias.

B. Upon completion of the required training, any licensed health care professional enrolled as a Medi-Cal Provider, acting within their scope of practice, and eligible to bill Evaluation and Management (E&M) codes can conduct and bill cognitive health assessments for IEHP Members.

C. In order to appropriately bill and receive reimbursement for conducting an annual CHA, Provider must do all of the following:

1. Complete the DHCS Dementia Care Aware CHA training prior to conducting the cognitive health assessment. This training is available at https://www.dementiacareaware.org;
    a. DHCS will maintain a list of Providers who have completed the training through which IEHP will verify whether Providers are eligible for reimbursement.
2. Administer the annual CHA as a component of an E&M visit including, but not limited to an office visit, consultation, or preventive medicine service (elements of the cognitive health assessment can be conducted by non-billing staff members acting within their scope of practice and under the supervision of the billing Provider);
3. Document all of the following in the Member's medical record and have such records available upon request:
    a. The screening tool or tools that were used (see list below);
    b. Verification that screening results were reviewed by the Provider;
    c. The results of the screening;
    d. The interpretation of results; and

[18] DHCS APL 21-014
[19] Ibid.
[20] DHCS APL 22-025, "Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older"

e. Details discussed with the Member and/or authorized representative and any appropriate actions taken in regard to screening results.

4. Use allowable CPT codes as outlined in the Medi-Cal Provider Manual.[21]

D. At least one (1) cognitive assessment tool listed below is required. Cognitive assessment tools used to determine if a full dementia evaluation is needed include, but are not limited to:

1. Patient assessment tools
   a. General Practitioner assessment of Cognition (GPCOG)
   b. Mini-Cog
2. Informant tools (Family members and close friends)
   a. Eight-item Informant Interview to Differentiate Aging and Dementia (AD8)
   b. GPCOG
   c. Short Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)

E. Providers must provide the appropriate necessary follow up services based on assessment scores and may include but are not limited to additional assessment or Specialist referrals.

Tobacco Prevention and Cessation

A. Providers must identify and track all tobacco use, both initial and annually, through the following activities:[22]
   1. Completion of the IHA questionnaire, which asks about smoking status and/or exposure to tobacco smoke;
   2. Annual assessment of tobacco use, 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.[23]

C. With regard to Members identified as using tobacco products, IEHP encourages Providers to implement the following interventional approach:[24]
   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 www.iehp.org:
      a. Use of the "5 A's" – Ask, Advise, Assess, Assist, and Arrange; and

[21] DHCS Medi-Cal Provider Manual, "Evaluation and Management"
[22] DHCS APL 16-014 Supersedes PL 14-006, "Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries"
[23] Ibid.
[24] Ibid.

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

2. Members are able to receive a minimum of four (4) counseling sessions of at least ten (10) minutes per session. Members may choose individual or group counseling conducted in person or by telephone.
   a. Individual, group, and telephone counseling is offered at no cost to Members who wish to quit smoking, whether or not those Members opt to use tobacco cessation medications.
3. Two (2) quit attempts per year are covered without prior authorization and without any mandatory breaks between quit attempts.
   a. The lists of appropriate Current Procedure Terminology (CPT) and International Classification of Diseases (ICD) codes for tobacco use may be accessed online through the IEHP non-secure Provider portal at www.iehp.org.
4. Members are to be referred to the California Smoker's Helpline (1-800-NO-BUTTS) or other comparable quit-line service. Providers are encouraged to use the Helpline's web referral, or if available in their area, the Helpline's e-referral system.

Immunizations

A. All Members must be assessed for and receive, if indicated, immunizations according to State and Federal standards. Immunizations are provided to all Members according to the most recent U.S. Public Health Service's Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule (see "Recommended Adult Immunization Schedule" found on the IEHP website).[25,26]

B. Immunizations are preventive services not subject to prior authorization requirements.[27]

C. IEHP requires network Providers to document each Member's need for ACIP-recommended immunizations as part of all regular health visits including, but not limited to, the following encounter types:[28]

1. Illness, care management, or follow-up appointments;
2. Initial Health Appointments (IHAs);
3. Pharmacy services;
   a. Adult Members may receive vaccines through three (3) options, without a Prior Authorization (PA):
      1) Vaccination from a licensed medical Provider;
      2) Vaccination from a pharmacy in the Vaccine Network;[29] and

[25] https://www.iehp.org/en/providers/provider-resources?target=forms
[26] Centers for Disease Control (CDC) Adult Immunization Schedule https://www.cdc.gov/vaccines/schedules/index.html
[27] DHCS APL 18-004
[28] Ibid.
[29] DHCS APL 16-009, "Adult Immunizations as a Pharmacy Benefit"

3) Vaccination from a Local Health Department.

4. Prenatal and postpartum care;
5. Pre-travel visits;
6. Sports, school, or work physicals;
7. Visits to a local health department (LHD); and
8. Well patient checkups.

D. Members may access LHDs for immunizations regardless of whether the LHD is within or outside IEHP's Provider Network.[30] IEHP will reimburse LHDs for the immunization administration fee.[31]

E. Providers must report Member-specific immunization information to the immunization registry that is part of the Statewide Immunization Information System (e.g. CAIR2). Reports must be made after a Member's IHA and after all healthcare visits that result in an immunization.[32] DHCS strongly recommends immunizations are reported within fourteen (14) days of administration.[33]

F. IEHP is not obligated to reimburse providers for immunization, as described in this policy, unless the provider enters into an agreement with the Plan.[34]

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
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[30] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[31] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 3.2.12, Immunizations
[32] DHCS APL 18-004
[33] Ibid.
[34] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 3.3.12, Immunizations

10. MEDICAL CARE STANDARDS

C. Pediatric Preventive Services
1. Well Child Visits

APPLIES TO:

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

POLICY:

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

DEFINITION:

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

PROCEDURES:

Initial Health Appointment

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.[5] See Policy 10A, "Initial Health Appointment" for more information.

1. For Members less than 18 months of age, within 120 calendar days of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures, whichever is sooner;[6] or

    a. Requests for IHA can be made by the Member, their parent(s), or guardian. When a request is made for an IHA, an appointment must be made for the Member to be

[1] Centers for Disease Control and Prevention, Advisory Committee on Immunization Practice (ACIP) Vaccine Recommendations and Guidelines - https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html
[2] California Health and Safety Code (Health & Saf. Code) § 1367.35
[3] United States Preventive Services Task Force (USPSTF), USPSTF A and B Recommendations - https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
[4] California Health and Safety (Health & Saf.) Code § 1367.34(b)
[5] Department of Health Care Services (DHCS) All Plan Letter (APL) 22-030 Supersedes APL 13-017 and Policy Letters 13-001 and 08-003, "Initial Health Appointment"
[6] https://www.aap.org/en/practice-management/bright-futures

examined within two (2) weeks of the request.[7] If the child is due for a well child visit based on the well child periodicity schedule, the visit must be scheduled within two (2) weeks.

2. For Members ages 18 months and older, within 120 calendar days of enrollment.

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

C. Diagnosis and treatment of any medical conditions identified through any pediatric preventive services assessment must be initiated within sixty (60) days of the assessment.[8]

Blood Lead Screening Test

A. Providers must provide oral or written anticipatory guidance to the parent or guardian of a child starting at 6 months of age and continuing until 72 months of age that includes, at a minimum, the information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age.[9]

B. Providers must order or perform blood lead level screening tests on all child Members in accordance with the following:[10]

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

C. All blood lead level screenings, confirmatory and follow-up testing must be performed and

[7] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.4, Services for Members less than Twenty-One (21) Years of Age
[8] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.4, Services for Members less than Twenty-One (21) Years of Age
[9] DHCS All Plan Letter (APL) 20-016 Supersedes All Plan Letter (APL) 18-017, "Blood Lead Screening of Young Children"
[10] Ibid.

interpreted in accordance with CLPPB guidelines.[11] Providers must follow the Centers for Disease Control and Prevention (CDC) requirements for Post-Arrival Lead Screening of Refugees contained in CLPPB issued guidelines (https://www.cdc.gov/immigrantrefugeehealth/).

D. Providers are not required to perform a blood lead screening test if either of the following applies:[12]

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

E. Providers must document refusals or reasons for not performing the blood lead screening in the child's medical record.[13]

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

F. Providers must follow the CLPPB guidelines when conducting blood lead screening tests, interpreting blood lead levels, and determining appropriate follow-up activities.[14]

G. IEHP will monitor compliance with CLPPB and DHCS guidelines for blood lead screening tests through the Facility Site Review and Medicare Record Review process (see Attachment, "DHCS MMCD Medical Record Review Standards" found on the IEHP website[15]).

H. IEHP informs its Providers, through the secure online IEHP Provider portal, of all child Members between the ages of six months to six years (i.e. 72 months), who have no record of receiving a blood lead screening test. IEHP identifies the age at which the required blood lead screenings were missed, including children without any record of a completed blood lead screening at each age. Providers are expected to test these child Members and provide the required written or oral anticipatory guidance to the parent/guardian of these child Members.[16]

[11] DHCS APL 20-016
[12] Ibid.
[13] Ibid.
[14] Ibid.
[15] https://www.iehp.org/en/providers/provider-resources?target=forms
[16] Title 17 California Code of Regulations (CCR) § 37100

Adverse Childhood Experience (ACE) Screening

A. ACE screenings in all inpatient and outpatient settings are only reimbursable for contracted Providers who complete the certified core ACEs Aware online training and who self-attest that they have completed this training; and have used the Pediatric ACEs Screening and Related Life-events Screener (PEARLS), which can be found in various languages at https://www.acesaware.org/learn-about-screening/screening-tools/screening-tools-additional-languages/.[17]

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

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

C. Applicable billing codes and frequency limits for Members under age 21 are outlined in the DHCS Medi-Cal Provider Manual, "Evaluation and Management."

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.[18] Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.[19]

B. PCPs, within their scope of practice, must provide SABIRT services for Members 11 years of age and older, including pregnant women as follows:[20]

   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) ;

[17] DHCS Medi-Cal Provider Manual, Evaluation and Management
[18] DHCS APL 21-014 Supersedes APL 18-014, "Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment"
[19] Ibid.
[20] Ibid.

b. Brief Addiction Monitor (BAM) ;

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

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

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

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

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

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

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

2. When the Member's screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or substance use disorder is present. Validated alcohol and drug assessment tools include, but are not limited to:[21]

   a. Alcohol Use Disorders Identification Test (AUDIT);

   b. Brief Addiction Monitor (BAM) ;

   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:[22]

   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.

[21] DHCS APL 21-014
[22] DHCS APL 21-014

4. The PCP must ensure the Member's medical record include the following:[23]
   a. The service provided (e.g., screen and brief intervention);
   b. The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record);
   c. The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record); and
   d. If and where a referral to an AUD or SUD program was made.
5. IEHP will make good faith efforts to confirm whether Members receive referred treatments and document when, where, and any next steps following treatment. If a Member does not receive referred treatments, IEHP will follow up with the Member to understand barriers and make adjustments to the referrals as needed. IEHP may also attempt to connect with the Provider to whom the Member was referred to facilitate a warm hand-off to necessary treatment.

C. IEHP informs Members of SABIRT services through Member-informing materials, including but not limited to the Evidence of Coverage (EOC).[24]

D. When a Member transfers from one PCP to another, the receiving PCP must attempt to obtain the Member's prior medical records, including those pertaining to the provision of preventive services.[25]

E. IEHP complies with all applicable laws and regulations relating to the privacy of substance use disorder records, as well as state law concerning the right of minors over 12 years of age to consent to treatment.[26,27] Please see Policies 7B, "Information Disclosure and Confidentiality of Medical Records" for information on confidentiality of medical records, and Policy 9E, "Access to Services with Special Arrangements" for more information on minor consent services.

Tobacco Prevention and Cessation

A. PCPs are required to provide interventions, including education or counseling, to prevent initiation of tobacco use in school-aged children and adolescents. Additionally, since secondhand smoke can be harmful to children, counseling parents who smoke, in a pediatric

[23] DHCS APL 21-014
[24] Ibid.
[25] Ibid.
[26] 42 CFR §§ 2.1 & 2.14 et. seq
[27] California Family Code § 6929

setting, is also recommended. Coverage of medically necessary tobacco cessation services, including counseling and pharmacotherapy, is mandatory for children up to the age of 21.[28]

B. With regards to Members identified as using tobacco products, IEHP encourages Providers to implement the following interventional approach:[29]

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

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

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

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

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

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

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

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

Cholesterol Screening

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

Diabetes Screening

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

[28] DHCS APL 16-014 Supersedes PL 14-006, "Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries"
[29] Ibid.

(2) or more risk factors (American Diabetes Association).

Dental Screening

A. For Members under the age of 21, a dental screening/oral health assessment must be performed as part of the IHA and of every periodic assessment, with annual dental referrals made for Members no later than 12 months of age of when a referral is indicated based on assessment (See Attachment, "Periodicity Schedule – Dental" found on the IEHP website.[30,31] For more information about the IHA, please see Policy_10A, "Initial Health Appointment." Dental assessments must include documentation in the medical record about the condition/findings of the mouth, teeth and gums.

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

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

D. PCPs are required to refer children to a dentist annually, starting with the eruption of the children's first tooth or at 12 months of age. A referral may be made earlier or more frequently if dental problems are suspected or detected. Members must be referred to appropriate Medi-Cal dental Providers.[32]

Tuberculosis Screening

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

Member Notification

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

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

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

[30] DHCS APL 23-005 Supersedes APL 19-010, "Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21
[31] https://www.iehp.org/en/providers/provider-resources?target=forms
[32] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.3.18, Dental

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

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

1. Screening services provided, and results thereof;[33]
2. Referral for diagnosis and treatment;
3. Results of diagnosis and treatment services;
4. Outreach and follow-up activities to assure that Members have received needed services; and
5. Notation of acceptance or refusal of services by Member, parent(s), or guardian.[34]

Reporting

A. Appropriate CPT codes must be used when reporting claim and encounter data. See Policy 21A, "Encounter Data Submission Requirements."

B. Blood Lead Screening Test Results[35]

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

[33] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.4, Services for Members under Twenty-One (21) Years of Age
[34] Ibid.
[35] DHCS APL 20-016

reasonable, and timely encounter data.[36,37]

5. IEHP will ensure blood lead screening encounters are identified using the appropriate indicators, as outlined in the most recent DHCS Companion Guide for X12 Standard File Format.

Provider Education

A. IEHP does not require CHDP certification; however, all PCPs must provide pediatric preventive services according to Bright Futures/AAP standards, and all PCPs must be trained on Bright Futures/AAP guidelines. See Policy 12D, "Early Periodic Screening, Diagnostic and Treatment" for more information.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☒ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

[36] DHCS All Plan Letter (APL) 14-019 Supersedes All Plan Letter (APL) 13-006, "Encounter Data Submission Requirements"
[37] DHCS All Plan Letter (APL) 17-005, "Certification of Document and Data Submissions"

10. MEDICAL CARE STANDARDS

C. Pediatric Preventive Services
2. Immunization Services

APPLIES TO:

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

POLICY:

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

PROCEDURES:

A. IEHP provides IPAs and all Primary Care Providers (PCPs) with updated copies of the immunization schedules as they become available from the Centers for Disease Control and Prevention (CDC) or Department of Health Care Services (DHCS) Immunization Branch.

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

C. IEHP contracts define immunization services as an IPA responsibility. Immunizations are preventive services not subject to prior authorization requirements.[4]

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

E. Vaccines for Children[5] – All PCPs with Members assigned ages 0-19 must enroll in the VFC program. VFC is a federally funded and state-operated program that supplies practitioners with vaccine for administration to children who meet eligibility requirements, including Medi-Cal enrollees. For more information on VFC call (877) 243-8832.

[1] https://www.iehp.org/en/providers/provider-resources?target=forms
[2] Department of Health Care Services (DHCS) All Plan Letter (APL) 18-004 Supersedes APL 07-15 and Policy Letter (PL) 96-013, "Immunization Requirements"
[3] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.4, Services for Members less than 21 Years of Age
[4] DHCS APL 18-004
[5] DHCS Medi-Cal Provider Manual, "Vaccines for Children (VFC) Program"

1. IEHP's Provider Relations team educates PCPs about the requirement to enroll in the VFC program during the new PCP onboarding training that takes place within 10 days of the PCP's effective date with the plan. The VFC enrollment requirement is also described in IEHP's Provider Training Guide.

F. Access:

1. To maximize the provision of immunizations, all Members should access immunization services through their assigned PCP.
2. Medi-Cal Members can also access immunization services through LHD immunization clinics regardless of whether they are within or outside IEHP's Provider Network.[6] When a Medi-Cal Member accesses an LHD clinic for immunizations, the LHDs should support non-duplication of immunization services. The LHD clinic utilizes the California Immunization Registry (CAIR2), the Member's California Immunization Record, or contacts the Member's PCP, to determine the immunization status of the Member. Members needing follow-up care are referred to their PCP by the LHD.
3. In instances where the Medi-Cal Provider Manual outlines immunization criteria less restrictive than ACIP criteria, Providers will provide immunizations in accordance with the less restrictive Medi-Cal Provider Manual criteria.

G. Recording and Tracking Member Immunizations

1. Providers must document each Member's need for ACIP-recommended immunizations as part of all regular health visits including, but not limited to, the following encounter types:[7]
   a. Illness, care management, or follow-up appointments;
   b. Initial Health Appointments (IHAs);
   c. Pharmacy services;
   d. Prenatal and postpartum care;
   e. Pre-travel visits;
   f. Sports, school, or work physicals;
   g. Visits to an LHD; and
   h. Well patient checkups.
2. Practitioners must maintain a system to record and track Member immunizations, which includes the following elements:

[6] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[7] DHCS APL 18-004

a. A record of immunizations must be maintained in each Member's medical record.[8]

b. Practitioners or Providers must review each medical record before a Member's appointment to determine any needed immunizations, which are then administered as appropriate during the appointment.

c. Members must be asked their immunization history and whether they have recently received any immunizations from out-of-network practitioners. If any recent immunizations are identified, the PCP verifies the immunization by looking up the Member in the Immunization Registry, or by confirming the Member's immunization history through the IEHP Provider website. The information must then be entered into the Member's medical record.

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

   a. Providers must report Member-specific immunization information to the immunization registry that is part of the Statewide Immunization Information System (e.g. CAIR2).[9] Reports must be made after a Member's IHA and after all healthcare visits that result in an immunization. IEHP strongly recommends immunizations are reported within fourteen (14) days of administration.[10,11]

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

4. Documentation should also be completed by the Provider when vaccines are declined or deferred by the Member. This documentation should include:[12]

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

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

[8] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.4, Services for Members less than 21 Years of Age
[9] Ibid.
[10] DHCS APL 18-004
[11] Ibid.
[12] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.4, Services for Members less than 21Years of Age

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

5. Practitioners must provide Members documentation of their immunizations if requested by the Member. This may be provided via the California Immunization Record.
6. Follow-up must be documented for missed appointments as outlined in Policy 9B, "Missed Appointments."

H. Reimbursement of LHDs for Immunizations administered to Medi-Cal Members only:

1. LHD clinics must be reimbursed an administration fee, at current Medi-Cal rates, for immunization services provided, excluding immunizations for which the Members is already up-to-date.[13]
2. Conditions for Reimbursement:
   a. The LHD must submit claims to the Member's assigned IPA on CMS-1500 billing forms, using the appropriate CPT and ICD codes.
   b. The LHD must provide immunization records.[14] If a Member refuses the release of medical information, the LHD must submit documentation of such a refusal.
   c. Claims from LHD for immunization services that were misdirected to IEHP will be returned to the LHD for resubmission to the appropriate IPA.
3. Vaccine Reimbursement Process for Providers not enrolled in the Vaccines for Children (VFC) Program is as follows:
   a. Providers must complete the CMS-1500 by including the appropriate CPT codes, quantity dispensed and billed amount.
   b. Claims are to be submitted to:

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

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

I. IEHP is not obligated to reimburse providers for immunization, as described in this policy, unless the provider enters into an agreement with the Plan.[15]

[13] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 3.3.12, Immunizations
[14] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[15] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 3.3.12, Immunizations

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

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 (PCP) providing care to IEHP Medi-Cal Members.

POLICY:

A. Primary Care Providers (PCPs) are responsible for supervising, coordinating, and providing initial and primary care to the Member; for initiating referrals; and for maintaining continuity of care, and for serving as the Medical Home for the Member.[1] PCPs are also 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 9E, "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."

[1] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment I, Definitions

10. MEDICAL CARE STANDARDS

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

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

10. MEDICAL CARE STANDARDS

D. Obstetrical Services

1. Guidelines for Obstetrical Services

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal 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.[1,2,3] When applicable, Providers are required to also follow Grade A and B recommendations from the U.S. Preventive Services Task Force (USPSTF).[4]

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.[5]

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.[6,7,8] Basic

[1] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.6, Pregnant and Postpartum Members
[2] DHCS Policy Letter (PL) 12-003 Supersedes PL 12-001 and 96-01, "Obstetrical Care – Perinatal Services"
[3] American Congress of Obstetrician and Gynecologists (ACOG), Guidelines for Perinatal Care, https://www.acog.org/clinical.
[4] USPSTF Grade A and B Recommendations, https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
[5] DHCS PL 12-003
[6] California Health and Safety Code (Health & Saf. Code) § 1367.695(b)
[7] DHCS PL 12-003
[8] NCQA, 2023 HP Standards and Guidelines, MED 1, Element A

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 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 – Medi-Cal" in Section 14, found on the IEHP website[9]).[10] 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.[11] 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."

Multidisciplinary Perinatal Services

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

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

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

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

9. Health Educator; or
10. Health Care Worker.

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

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

Perinatal Care

A. The content and timing of perinatal care should be varied according to the needs and risk status of the Member and their fetus. Typically, a Member with an uncomplicated first pregnancy is examined every four (4) weeks for the first 28 weeks of pregnancy, every two (2) weeks until 36 weeks of gestation, and weekly thereafter. Members with active medical or OB problems, as well as Members at the extremes of reproductive age, should be seen more frequently, at intervals determined by the nature and severity of the problems. [12]

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: [13]

1. Family planning and pregnancy spacing (see Policy 10G, "Family Planning Services");
2. Immunization status (see Policy 10B, "Adult Preventive Services");
3. Risk factors for sexually transmitted infections (see Policy 10H, "Sexually Transmitted Infection Services");
4. Substance use, including alcohol, tobacco, and recreational and illicit drugs;
5. Exposure to violence and intimate partner violence;
6. Medical, surgical, and psychiatric histories;
7. Current medications;
8. Family history;
9. Genetic history;

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

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 the IEHP website[14]).[15,16,17] 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.[18,19]

E. All Members must receive a prescription for prenatal vitamins as a standard of care.[20]

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

Tobacco Prevention and Cessation

A. The USPSTF recommends that clinicians ask all pregnant people about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant people who use tobacco (Grade A recommendation). Because of the serious risk of smoking

[14] https://www.iehp.org/en/providers/provider-resources?target=forms
[15] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.3.6, Pregnant and Postpartum Members
[16] 22 CCR § 51348(b)(1)
[17] Click here for the most current forms: https://www.acog.org/clinical-information/obstetric-patient-record-forms
[18] ACOG, Guidelines for Perinatal Care, https://www.acog.org/clinical
[19] 22 CCR § 51348(b)(2)
[20] 22 CCR § 51348(c)(3)

to the pregnant smoker and fetus, whenever possible, Members should be offered tailored, one-on-one counseling exceeding minimal advice to quit, as described below.[21]

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.
2. Providers are required to ask all pregnant Members if they use tobacco or are exposed to tobacco smoke at every doctor visit. Pregnant Members who smoke should obtain assistance with quitting throughout their pregnancies.
3. ACOG recommends clinical interventions and strategies for pregnant Members who use tobacco.[22]
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 sixty (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.[23]
    1. The current services provided by the California Prenatal Screening Program may be found on the program's website: https://www.cdph.ca.gov/Programs/CFH/DGDS/pages/pns.

[21] DHCS APL 16-014 Supersedes PL 14-006, "Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries"
[22] The American Congress of Obstetricians and Gynecologists, "Committee Opinion Smoking Cessation During Pregnancy," Number 721, October 2017
[23] DHCS Medi-Cal Provider Manual, "Genetic Counseling and Screening"

2. Abnormal screening results are then followed up by State-approved diagnosis centers. (See "California Prenatal Screening Program" found on the IEHP website[24]). 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.[25]

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.[26]

Intrapartum Care

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

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

Postpartum Care

A. As the primary Practitioner of care during pregnancy, the OB Practitioner is responsible for identifying the newborn's Physician on the antepartum record. In addition, the OB Practitioner, in conjunction with the 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.

[24] https://www.iehp.org/en/providers?target=forms
[25] https://www.cdph.ca.gov/Programs/CFH/DGDS/CDPH%20Document%20Library/PNS%20Documents/PDCs_by_County.pdf
[26] DHCS PL 12-003

D. All Members should undergo a comprehensive postpartum visit within the first six (6) weeks after birth. This visit should include a full assessment of physical, social, and emotional well-being. The postpartum visit includes but is not limited to educating the Member on family planning, immunization, and referrals to a pediatric Practitioner for Well Child services and the Supplemental Food Program for Women, Infants and Children (WIC). Please see Policies 10C1, "Pediatric Preventive Services – Well Child Visits," 10C2, "Pediatric Preventive Services – Immunization Services," 10E, "Referrals to the Supplemental Food Program for Women, Infants, and Children," and 10G, "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.[27] 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.[28] Please see Policy 12A2, "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 or 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.

[27] DHCS PL 12-003
[28] CA Health & Saf. Code § 1373.96

10. MEDICAL CARE STANDARDS

D. Obstetrical Services

1. Guidelines for Obstetrical Services

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
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10. MEDICAL CARE STANDARDS

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 Medi-Cal 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.[1,2,3]

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.[4,5,6,]

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.[7]

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.

E. Out-of-network CNMs and FBCs must be reimbursed no less than the Medi-Cal Fee-for-

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 18-022 Supersedes APL 16-017, "Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services"
[2] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[3] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[4] California Health and Safety Code (Health & Saf. Code) § 1367.695(b)
[5] DHCS Policy Letter (PL) 12-003, "Obstetrical Care-Perinatal Services"
[6] National Committee for Quality Assurance (NCQA), 2022 Health Plan (HP) Standards and Guidelines, MED 1, Element A
[7] Title 22, California Code of Regulations (CCR) § 51345

Services (FFS) rate for services provided if IEHP or the Member's assigned IPA is unable to provide access to in-network CNMs or FBCs.[8]

F. Authorization and provision of home birth services are subject to review for Member safety and adherence to clinical standards of care.

G. IEHP informs Members of their right to obtain services from out-of-network CNMs, LMs and FBCs, when access to these provider types is not available in-work. Members are informed through the IEHP Medi-Cal Member Handbook and during telephonic encounters.[9,10]

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☒ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

[8] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 3.3.8, Non-Contracting Certified Nurse Practitioner (CNP) and Licensed Midwife (LN) Providers
[9] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.1, Specific Requirements for Access to Programs and Covered Services
[10] DHCS APL 18-022

10. MEDICAL CARE STANDARDS

D. Obstetrical Services

3. PCP Provision of Obstetric Care

APPLIES TO:

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

POLICY:

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

PROCEDURES:

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

1. Education & Training. All practitioners must meet the education and training requirements for one (1) of the following specialties, set for forth by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA).
    a. Family Practice, also applicable to:
        1) Family Practice 1: Family Practice Providers with OB Services
        2) Family Practice 2: Family Practice Providers that includes OB services and delivery
    b. Obstetrics and Gynecology
2. Hospital privileges. The Practitioner must have admitting privileges that include delivery, at an IEHP participating Hospital. For those Practitioners who do not hold their own admitting privileges that includes delivery, the following documentation must be provided for review:
    a. Family Practice 1 Providers must provide a signed agreement that states Member transfers will take place within the first 28 weeks of gestation and a protocol for identifying and transferring high risk Members with a contracted and credentialed OB.
        1) The OB must be within the same network as the Family Practice Provider and hold admitting privileges to the IEHP contracted Hospital linked with that network.
    b. Family Practice 2 Providers must hold admitting privileges with delivery, at an IEHP participating Hospital and provide a written agreement for an available OB back up Provider is required.

1) The OB must be credentialed, contracted and hold admitting privileges to the IEHP Hospital linked with the Family Practice Provider; and

2) Provide a protocol for identifying and transferring high risk Members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc.).

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

1) In lieu of having full Hospital delivery privileges, provide a written agreement with an OB Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.), must be available for consultations, as needed and that the OB will provide prenatal care after 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 (CMO). 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 through an application for IEHP's Direct Network or Provider Profile from an IPA, IEHP staff schedules a site visit to determine if all facility criteria are met.

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

b. IEHP provides written notice to requesting Practitioners after the site visit either approving them under, or not approving them with the reasons noted. 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 CMO within 30 days of the notification of the decision as stated in

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

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

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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[2] https://www.iehp.org/en/providers/provider-resources?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 Medi-Cal 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.[1]

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:[2]

   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:[3]

   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 Members, as well as infants and children under the age of five (5) years, who would benefit from participating in the WIC

[1] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.3.20, Women, Infants, and Children (WIC) Supplemental Nutrition Program
[2] https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/HowCanIGetWIC.aspx
[3] Title 42 Code of Federal Regulations (CFR) § 431.635(c)(2)

program.[4,5]

Referral

A. Each county WIC program can provide OBs, Pediatricians, and other PCPs with WIC informational brochures, educational materials for Members, and PM 247 or CDPH 247A forms for their use when referring Members (See Attachment, "WIC Referral Forms" found in the IEHP website[6]).

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;[7]
   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.[8]

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 https://wic.sbcounty.gov/doiqualify/

[4] Title 42 Code of Federal Regulations (CFR) § 431.635(c)(2)
[5] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.3.20, Women, Infants, and Children (WIC) Supplemental Nutrition Program
[6] https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/HowCanIGetWIC.aspx
[7] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.3.20, Women, Infants, and Children (WIC) Supplemental Nutrition Program
[8] Ibid.

3. Out of County - (951) 360-8000

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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10. MEDICAL CARE STANDARDS

F. Sterilization Services

APPLIES TO:

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

POLICY:

A. IEHP Medi-Cal Members may obtain sterilization services (tubal ligation or vasectomy) at any qualified family planning Practitioner in or out of the IPA's IEHP network.[1]

B. IEHP ensures that obtaining and documenting informed consent for services, including sterilization, comply with State, Federal and contractual requirements.[2] See Policy 7C, "Informed Consent."

PROCEDURES:

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

B. Access to Sterilization Services

1. The Medi-Cal Member selects a qualified family planning Practitioner of their choice within the IEHP network, or out-of-network.[3] 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

[1] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[2] Title 22, California Code of Regulations (CCR) § 51305.1 et seq.
[3] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services

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.[4]
2. The PM 330 Sterilization Consent Form, which contains federal funding language, must be used, as mandated by the State of California (See Attachments, "PM 330 Sterilization Consent Form – English" and "PM 330 Sterilization Consent Form – Spanish" found on the IEHP website[5]).[6]
    a. One (1) copy of the State of California approved booklets must be furnished to the Member, along with the consent forms.[7]
    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.[8]
        1) The PM 330 Sterilization Consent Form must be signed by the Member after the discussion has taken place.[9] If an interpreter is used, he/she must also sign the consent form verifying his/her part in the discussion.[10] 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.[11]
        3) Written informed consent must have been given at least thirty (30) days and no more than one hundred eighty (180) days before the procedure is performed.[12] A copy of the consent form must be given to the Member.[13]
        4) A hysterectomy requires an additional consent form and is only covered when medically necessary. A hysterectomy is not compensated under the Medi-Cal

[4] 22 CCR § 51305.1
[5] https://www.iehp.org/en/providers/provider-resources?target=forms
[6] 22 CCR § 51305.4
[7] 22 CCR § 51305.3
[8] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.14, Site Review
[9] 22 CCR § 51305.4
[10] Ibid.
[11] 22 CCR § 51305.3
[12] 22 CCR § 51305.1
[13] 22 CCR § 51305.3

program if performed or arranged for the sole purpose of rendering the Member sterile.

5) Sterilization may be performed during emergency abdominal surgery or premature delivery if the Member consented to sterilization at least thirty (30) days prior to the intended date of sterilization or the expected date of delivery and at least seventy-two (72) hours have passed between the time that written consent was given and the time of the emergency surgery or premature delivery.[14] The consent must also have been signed seventy-two (72) hours prior to the Member having received any preoperative medication.[15]

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

7) Original copies of the informed consent must be filed in the Member's medical record.[16]

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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[14] 22 CCR § 51305.3
[15] DHCS Medi-Cal Provider Manual, "Sterilization"
[16] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.14, Site Review

10. MEDICAL CARE STANDARDS

G. Family Planning Services

***APPLIES TO*:**

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

POLICY:

A. Medi-Cal Members have the right to access, without prior authorization, any qualified family planning Practitioner within or outside of the IEHP or the Member's IPA's network.[1,2,3]

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.[4]

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.[5]

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 Medi-Cal Members at any qualified family planning Practitioner. IEHP is responsible for the facility charges resulting from qualifying inpatient family planning services.

B. The following list of services may be provided to IEHP Medi-Cal Members as part of the family planning benefit:[6]

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

   2. History and physical examination limited to immediate problem;

[1] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[2] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[3] DHCS All Plan Letter (APL) 18-019 Supersedes APL 16-003, "Family Planning Services Policy for Self-Administered Hormonal Contraceptives"
[4] DHCS Medi-Cal Provider Manual, "Family Planning"
[5] DHCS APL 18-019
[6] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Specific Requirements for Access to Programs and Covered Services

3. Laboratory tests, if medically indicated as part of decision-making process for choice of contraceptive methods;
4. Diagnosis and treatment of Sexually Transmitted Infections (STIs);
5. Screening, testing, and counseling of at-risk individuals for HIV and referral for treatment;
6. Follow-up care for complications associated with contraceptive methods issued by the family planning Provider;
7. Provision of contraceptive pills or patches, vaginal rings, devices, and supplies in an on-site clinic and billed by a qualified family planning Provider or Practitioner. The formulary status and quantity limit are determined based on guidance from Department of Health Care Services (DHCS).
8. Tubal ligation;
9. Vasectomy; and
10. Pregnancy testing and counseling.

C. IEHP will cover up to a 12 month supply of Food and Drug Administration (FDA)-approved, self-administered hormonal contraceptives when dispensed or furnished at one time by a Provider or Pharmacist or at a location licensed or authorized to dispense drugs or supplies. The following are not considered part of family planning services:[7]

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

D. A Physician, Physician Assistant, Certified Nurse Midwife, and Nurse Practitioner are authorized to dispense medication. A registered nurse who has completed required training may also dispense contraceptives when Evaluation and Management (E&M) procedure 99201, 99211, or 99212 is performed and billed with modifier 'TD.'[8]

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

[7] DHCS Medi-Cal Provider Manual, "Family Planning"
[8] DHCS APL 18-019

these services in a timely and confidential manner. Medi-Cal Members are informed upon enrollment that they have a right to access family planning services within and outside IEHP's network without prior authorization.[9]

B. Members receive family planning and freedom of choice information from IEHP in the following ways:[10]

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.[11] A sample informed consent for contraceptive methods other than sterilization is attached (See Attachments, "Contraceptive Informed Choice Form – English" and "Contraceptive Informed Choice Form – Spanish" found on the IEHP website[12]). 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.[13]

Accessing Family Planning Services

A. Medi-Cal Members select a qualified family planning Practitioner of their choice within the IEHP network or out-of-network.[14] IEHP Member Services refers Members who request additional information to the State Office of Family Planning at (916) 650-0414 to receive more information on qualified family planning Practitioners.

B. Minors aged 12 and older may access family planning services without parental consent.[15] Please see Policy 9E, "Access to Services with Special Arrangements" for more information.

C. Out-of-network family planning practitioners are expected to demonstrate a reasonable effort to coordinate services with IEHP network Practitioners, including educating Members to

[9] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Specific Requirements for Access to Programs and Covered Services
[10] Ibid.
[11] Ibid.
[12] https://www.iehp.org/en/providers/provider-resources?target=forms
[13] Title 22, California Code of Regulations (CCR) § 51305.3
[14] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Specific Requirements for Access to Programs and Covered Services
[15] CA Family Code (Fam. Code) § 6925

return to their Primary Care Provider (PCP) for continuity and coordination of care.

D. Members should be encouraged to approve release of their medical records from the family planning provider to the PCP so that the PCP may coordinate future care accordingly and avoid duplication of already provided services. A sample release form for out-of-network family planning services is attached (See Attachments, "Auth or Refusal to Release Medical Record – Out-of-Network Family Planning – English" and "Auth or Refusal to Release Medical Record – Out-of-Network Family Planning – Spanish" found on the IEHP website[16]).

E. If they desire, Members may sign a modified release of information form that preserves their medical record confidentiality but allows family planning service Practitioners adequate information to bill the Member's IPA. Practitioners must make such a form available to Members. A sample form in both English and Spanish is attached (See Attachments, "Authorization for Use and Disclosure of Personal Health Information – English" and "Authorization for Use and Disclosure of Personal Health Information – Spanish" found on IEHP website[17]).

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 Medi-Cal Members accessing out-of-network practitioners for family planning.

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

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

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.[18]

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 16C, "IPA, Hospital and Practitioner Grievance and Appeal Resolution Process."

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☒ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

[18] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provisions 3.3.9, Non-Contracting Family Planning Providers

10. MEDICAL CARE STANDARDS

H. Sexually Transmitted Infection Services

APPLIES TO:

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

POLICY:

A. All Medi-Cal 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.[1,2,3]

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).[4]

B. Licensed Physicians, Nurse Practitioners, Certified Nurse Midwives, or Physician Assistants who are practicing within their authorized scope of practice may prescribe, dispense, furnish, or otherwise provide prescription antibiotic medications to the sexual partner or partners of a Member with a diagnosed sexually transmitted chlamydia, gonorrhea or other sexually transmitted infection, as determined by the California Department of Health Care Services (DHCS), without examination of the Member's sexual partner or partners.[5]

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

Access Within Network

A. Medi-Cal Members may choose to receive STI services from any qualified Practitioner, in IEHP's network or their assigned IPA's network without prior authorization.[6,7,8,9]

B. PCPs are required to offer all Members appropriate STI services, including screening,

[1] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[2] DHCS Policy Letter (PL) 96-09, "Sexually Transmitted Disease Services in Medi-Cal Managed Care"
[3] California Health & Safety Code (Health & Saf. Code) § 1367.31
[4] DHCS PL 96-09
[5] California Health and Safety Code (Health & Saf. Code) § 120582
[6] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures
[7] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[8] DHCS PL 96-09
[9] CA Health & Saf. Code § 1367.31

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.[10,11]

B. Out-of-network practitioners may call IEHP Member Services at 1-800-440-IEHP (4347) for Medi-Cal eligibility, benefits, benefit exclusions, limitations, and the name of the Member's IEHP PCP. IEHP encourages the out-of-network practitioner to refer the Member back to their PCP to maintain continuity of care.

Confidentiality and Reporting

A. Members aged 12 years and older, may access STI services from Practitioners noted above without parental consent.[12] See Policy 9E, "Access to Services with Special Arrangements" for more information.

B. The expressed, written consent of the Member or legal representative is required for the release of medical records to another party outside the Practitioner. If they desire, Members may sign a modified release of information form that preserves their medical record confidentiality but gives STI service Practitioners adequate information for billing purposes.[13] Practitioners must make such a form available to their Members (see Attachments "Authorization for Use and Disclosure of Personal Health Information – English" and "Authorization for Use and Disclosure of Personal Health Information – Spanish" found on the IEHP website[14])

C. All Practitioners providing STI services are required by law to report individuals with certain communicable diseases to the LHD. See Policy 10K, "Reporting Communicable Diseases to Public Health Authorities."

D. Medical records for Members presenting for STI evaluation must be maintained to protect the confidentiality of the Member.[15] 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

[10] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[11] CA Health & Saf. Code § 1367.31
[12] CA Family Code (Fam. Code) § 6926
[13] DHCS PL 96-09
[14] https://www.iehp.org/en/providers/provider-resources?target=forms
[15] DHCS PL 96-09

by the Member, recording or placing in the medical record all pertinent information (assuming consent from the Member) and determining any need for follow-up care, testing or treatment.

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

Reimbursement for Out-of-Network Services

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

B. The reimbursement for out-of-network practitioners not associated with a LHD for STI services is limited to one (1) office visit per disease episode for:[16,17]

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

C. For LHDs, reimbursement is available as outlined below:[18]

1. One (1) visit is reimbursable for initial treatment of vaginal or urethral discharge for symptoms and signs consistent with trichomoniasis.
2. Up to six (6) visits are reimbursable for primary and secondary syphilis clinical and serological follow-up and treatment. Documentation should include serologic test results upon which treatment recommendations were made. Members found to have reactive serology while showing no other evidence of disease should be counseled about the importance of returning to a Provider or Practitioner for follow-up and treatment of

[16] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services
[17] DHCS PL 96-09
[18] DHCS PL 96-09

possible latent syphilis.

3. Initial visit and up to two (2) follow-up visits are reimbursable for chancroid diagnosis and clinical improvement confirmation.
4. A maximum of three (3) visits are reimbursable for lymphogranuloma or granuloma inguinale, based upon the time involved to confirm the diagnosis and the necessary therapy duration necessary.
5. One (1) visit is reimbursable for presumptive diagnosis and treatment of herpes simplex.
6. Gonorrhea, non-gonococcal urethritis, and chlamydia can often be presumptively diagnosed and treated in one (1) visit. For individuals with gonorrhea or chlamydia not presumptively treated at the first visit, a second visit for treatment is reimbursed.
7. One (1) visit is reimbursable for diagnosis and therapy initiation for human papilloma virus, with referral to PCP for further follow-up and treatment.
8. Initial visits and two (2) follow-up visits for pelvic inflammatory disease diagnosis, treatment, and urgent follow-up are reimbursable. Members should be referred to their PCP for continued follow-up after the initial three (3) visits have been provided by the LHD.

D. STI services and laboratory testing provided through out-of-network practitioners must be reimbursed at the Medi-Cal fee-for-service (FFS) rate, unless otherwise negotiated in subcontracts with IPAs.[19]

E. Guidelines for treatment of various STIs may require that HIV testing and counseling be performed. These tests and counseling procedures are reimbursed at the appropriate Medi-Cal FFS rate.[20] See Policy 10I, "HIV Testing and Counseling" for specific information on HIV testing and counseling procedures.

F. Conditions for Reimbursement

1. The out-of-network practitioner must submit claims to the Member's assigned IPA or the IEHP Claims Department on CMS 1500 or UB-04 billing forms using the appropriate CPT and ICD codes that reflect STI diagnosis and treatment.
2. The STI treating Practitioner must provide proof of service. If a Member refuses the release of medical information, the treating Practitioner must submit refusal documentation.[21,22]
3. STI treating Practitioners are not reimbursed for services that fall outside the specific conditions and visits noted above.
4. STI treating Practitioners are only reimbursed for services provided by a Practitioner

[19] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 3.3.10, Sexually Transmitted Disease (STD)
[20] DHCS PL 96-09
[21] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 3.3.10, STD
[22] DHCS PL 96-09

within their licensed scope of practice.[23]

5. STI treating Practitioners are only reimbursed for services provided to IEHP Member.

G. IEHP and its IPAs must pay claims within 30 days of claims receipt.

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

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☒ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

[23] Ibid.

10. MEDICAL CARE STANDARDS

I. HIV Testing and Counseling

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal 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.[2,3,4,5]

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).[6]

B. IEHP provides all IPAs and PCPs with an updated list of LHD operated or contracted HIV testing and counseling sites (See Attachment, "HIV Testing Sites – Riverside and San Bernardino" found on the IEHP website[7]).

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.

[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] Department of Health Care Services (DHCS)-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.8, Specific Requirements for Access to Programs and Covered Services

[3] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 2.3.1, Prior Authorizations and Review Procedures

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

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

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

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

B. The assessment performed by the PCP must align with the most up-to-date recommendations from the CDC.[8]

C. For those Members identified by the PCP as at risk for HIV infection, one (1) of the following must occur:[9]

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

D. PCPs are responsible for identifying Members who may potentially require care management services and notifying the IPA Care Management (CM) Department. PCPs may also submit a completed CM Referral Form to IEHP to refer the Member for care management. See Policy 12A1, "Case Management Requirements – PCP Role."

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

1. As part of a Family Planning visit with any qualified family planning Practitioner. See Policy 10G, "Family Planning Services";
2. As part of an STI visit at a LHD or other qualified Practitioner. See Policy 10H, "Sexually Transmitted Infection (STI) Services"; or
3. Direct self-referral for anonymous or confidential HIV testing and counseling services at a LHD operated or contracted site.

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

HIV Testing and Counseling for Children

A. PCPs and Specialists caring for Members who are children must offer to parents or legal guardians HIV counseling, education, and testing, where appropriate, to infants, children and adolescents in the following categories:[10]

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

[8] CDC HIV Screening in Clinical Settings: https://www.cdc.gov/hiv/clinicians/screening/clinical-settings.html
[9] DHCS PL 97-08
[10] Ibid.

f. Any abandoned newborn infants.

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

B. Medi-Cal Members that are under the age of 21 years who are confirmed HIV positive must be referred to the California Children's Services (CCS) Program.[11] See Policy 12B, "California Children's Services (CCS)."

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:[12, 13]

1. Mode of transmission;
2. Risk reduction and behavior modification including methods to reduce the risk of perinatal transmission; and
3. Referral to other HIV prevention and psychosocial services.

B. IEHP requires that all prenatal care Practitioners within its network and that of 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.[14, 15]

C. All IEHP and IPA prenatal care Practitioners are required to discuss with the Member:[16]

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.[17]

[11] DHCS PL 97-08
[12] CA Health & Saf. Code § 125107
[13] DHCS PL 97-08
[14] Ibid.
[15] USPSTF, Screening for HIV Infection: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening
[16] DHCS PL 97-08
[17] Ibid.

Out-of-Network Reimbursement for Medi-Cal Members

A. HIV testing and counseling services provided through LHDs, sites subcontracted by LHDs or qualified family planning Practitioners as part of a family planning visit must be reimbursed at the Medi-Cal fee-for-service rate, unless otherwise negotiated between Practitioners.[18,19]

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 16C, "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 state and federal regulations.[20] 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.[21]
2. The Practitioner ordering the test may **not** disclose the results of the test to IEHP, the Member's IPA or any other health care service plan.[22,23]
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.[24] IEHP provides sample consent forms that may be used (See Attachments, "Consent for HIV Test – English" and "Consent for HIV Test – Spanish" found on the IEHP website).[25] 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

[18] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 3.3.11, HIV Testing and Counseling
[19] DHCS PL 97-08
[20] CA Health & Saf. Code, § 120975
[21] CA Health & Saf. Code, § 120985
[22] Ibid.
[23] CA Health & Saf. Code, § 121010
[24] CA Health & Saf. Code, § 120990
[25] https://www.iehp.org/en/providers/provider-resources?target=forms

for purposes directly related to the Member's health care,[26] all IEHP and IPA network Practitioners must obtain written consent from the Member to disclose HIV test results (See Attachments, "Authorization for Use and Disclosure of Personal Health Information – English" and "Authorization for Use and Disclosure of Personal Health Information – Spanish" found on the IEHP website).[27] "Authorization for Use and Disclosure of Personal Health Information" forms can be found on the IEHP website.[28]

Reporting

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

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

26 CA Health & Saf. Code, § 120985
27 https://www.iehp.org/en/providers/provider-resources?target=forms
28 https://www.iehp.org/en/providers/provider-resources?target=forms

10. MEDICAL CARE STANDARDS

J. Tuberculosis Services

APPLIES TO:

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

POLICY:

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

DEFINITIONS:

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

PROCEDURES:

Provider Responsibilities

A. Risk Assessment

1. PCPs must assess Members for risk factors for developing TB at a minimum during these encounters:
    a. Well child visits (See Policy 10C1, "Pediatric Preventive Services – Well Child Visits"); and
    b. Initial Health Appointment. See Policy 10A, "Initial Health Appointment".
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.

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

Laboratories must report to the LHD testing results, including molecular and pathologic results, suggesting of diseases of public health importance.[7,8,9] See Policy 10K, "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 educated about TB prevention, per the most recent CDC guidelines. [10]

C. Public Health Reporting

1. Providers must report all confirmed (TB3) or highly suspected (TB5) active TB cases to the LHD in the county where the Member resides. [11] Please see Policy 10K, "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.[12]
3. PCPs must cooperate with LHD in conducting contact tracing and outbreak investigations potentially involving Members, as well as for any requests for medical records, screening, diagnostic work-up, and any other pertinent clinical or administrative information.[13,14]
4. PCPs must provide appropriate examination and treatment to Members, identified by the LHD as contacts. These must be provided in a timely manner (usually within seven (7) days). Examination results must be reported back to the LHD Tuberculosis Program staff in a timely manner, as defined by the LHD. [15,16]
5. Providers are encouraged to enroll in the California Reportable Disease Information Exchange (CalREDIE). The CalREDIE is a system that the California Department of Public Health has implemented for electronic disease reporting and surveillance.

D. Direct Observed Therapy (DOT)

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

1. The following groups of individuals are at risk for difficulty adhering to the treatment of TB. Providers shall refer Members with active TB and have any of these risks to the LHD:[17]
   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: [18]
   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.[19]
3. For Members receiving DOT, the PCP must share clinical information with the LHD Tuberculosis Program as needed and requested. The PCP must promptly notify the LHD Tuberculosis Program of any significant changes in the Member's condition or response to medical treatment including adverse drug reactions and dosage changes. IEHP provides all medically necessary medication for Members with TB.

IEHP and IPA Responsibilities

A. IEHP and its IPAs provide case management and care coordination for all suspected and active TB cases. IEHP and IPA CM provide the coordination of TB care with the LHD.[20] See Policy 25C1, "Case Management Requirements – Delegation and Monitoring."

[17] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.3.19, Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)
[18] Ibid.
[19] Ibid.
[20] Ibid.

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.[21]

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

[21]DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 4.3.19, Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)

10. MEDICAL CARE STANDARDS

K. Reporting Communicable Diseases to Public Health Authorities

APPLIES TO:

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

POLICY:

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

PURPOSE

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

PROCEDURES:

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

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

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

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

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

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

the report:

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

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

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

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

Riverside County

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

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

Night & Weekend Emergency: (951) 358-5107

San Bernardino County

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

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

Night & Weekend Emergency: (909) 356-3805

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Date:	January 1, 2024	

10. MEDICAL CARE STANDARDS

L. Vision Examination Level Standards

APPLIES TO:

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

POLICY:

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

PROCEDURES:

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

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

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

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

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

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

D. IEHP recognizes the importance of allowing Members to have prompt diagnosis and treatment of acute eye conditions. Under the Therapeutic Pharmaceutical Agent (TPA) Certification Program, IEHP-credentialed and TPA-certified Providers may provide specific services to Members without a referral from the Member's PCP. In addition to performing TPA services an Optometrist with TPG or TLG certification can diagnose and treat primary open angle glaucoma in patients over the age of 18 years old. IEHP-credentialed Ophthalmology Providers should continue to work through their contracted IPA to provide these services.

E. To ensure Member continuity of care, all Providers participating in the TPA Program are responsible for notifying the Member's PCP that medical services have been provided. For more information on the TPA Program, please see to Policy 12L, "Vision Services."

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
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10. MEDICAL CARE STANDARDS

M. Mandatory Elder or Dependent Adult Abuse Reporting

APPLIES TO:

A. This policy applies to Mandated Reporters who treat or have contact with IEHP Medi-Cal 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, of any Elder or Dependent Adult who does not have the capacity to consent to such

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

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, 60 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 Provider, clergy member, or employee of a county adult protective services agency or a local law enforcement agency.

E. **Ombudsman** – the State Long-Term Care Ombudsman, local ombudsman coordinators, and

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

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

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

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.

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

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

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)

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.

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

10. MEDICAL CARE STANDARDS

M. Mandatory Elder or Dependent Adult Abuse Reporting

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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10. MEDICAL CARE STANDARDS

N. Mandatory Child Abuse and Neglect Reporting

APPLIES TO:

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

POLICY:

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

B. PCPs are Mandated Reporters[1] and as such they are responsible for directly informing Child Protective Services within their respective county, of identified or suspected abuse or neglect cases and filing reports with appropriate county agencies.

C. Other Mandated Reporters, who are also responsible to directly report identified or suspected child abuse or neglect include IEHP professional staff and:

   1. Medical, Dental and Hospital Personnel
   2. Mental Health Professionals and Counselors
   3. Social Service Personnel

D. IEHP adopts the definition of child abuse/neglect from the California Child Abuse and Neglect Reporting Act: physical injury or death inflicted by other than accidental means upon a child by another person, sexual abuse, neglect, the willful harming or injuring of a child or the endangering of the person or health of a child, and unlawful corporal punishment or injury.[2] For the full definition of "child abuse or neglect," see California Penal Code Section 11165.6.

E. Mandated Reporters, will report identified or suspected abuse or neglect such as:

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

PROCEDURES:

Identification of Suspected Abuse or Neglect Cases

A. At the health plan level, Providers, care managers, and Utilization Management (UM) personnel are able to identify and report incidents of potential child abuse or neglect. Any obligation to investigate the particulars of any case rests with Child Protective Services. This

[1] California Penal Code, § 11164 *et seq*.
[2] Ibid.

allows Mandated Reporters to act based only upon clinical suspicion, without being constrained by the need to investigate or to cast judgment.

B. Health care givers must be alert for signs of possible child abuse or neglect including, but not limited to, the following signs and symptoms:

1. Evidence of malnutrition, starvation, dehydration, failure to thrive;
2. Chronic neglect;
3. Sexual assault;
4. Exposure to controlled substances, street drugs, or alcohol;
5. Conflicting or inconsistent accounts of incidents and injuries;
6. Depression not responding to appropriate therapy or characterized by suicidal thoughts;
7. Shaken baby syndrome;
8. Blunt force trauma;
9. Infection due to lack of medical treatment;
10. A series of accidents, bruises, or fractures over time;
11. Unexplained illness or injury;
12. Poor or worsening school or work performance not otherwise explained;
13. On office visit, the presence of physical findings of trauma inconsistent with a Member's stated history, or inconsistent with the parent's, caregiver's, or guardian's history. Examples include a stated mechanism of injury not consistent with a child's developmental age (e.g., a child who could not have rolled off a bed); and
14. On office visit, the presence of behavioral or emotional clues pointing toward possible abuse or neglect. These may include excessive hostility between a Member and his/her parent or caregiver; excessively avoidant, sullen, fearful, submissive, or anxious behaviors on the part of the Member; or sexually inappropriate, explicit, or familiar behavior on the part of the Member during the office visit.

C. In addition, Mandated Reporters have a variety of further information sources for the identification of child abuse or neglect cases including the following:

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 Pediatricians, PCPs, and other health care Providers that reveal unusual physical or emotional findings;
5. Abuse cases identified during the utilization management or care management process;
6. Requests for assistance received by Member Services from victims of abuse; and
7. Calls to the 24 Hour Nurse Advice Line from victims of abuse.

Reporting Suspected Abuse or Neglect Cases

A. Whenever the Mandated Reporter, in the their professional capacity or within the scope of employment, has knowledge of or observes a child whom the Mandated Reporter knows or reasonably suspects has been the victim of child abuse or neglect, the Mandated Reporter must make an initial report by telephone to the agency immediately or as soon as is practicably possible, and shall prepare and send, fax, or electronically transmit a written follow-up report within 36 hours of receiving the information concerning the incident.[3]

B. Mandated Reporters are responsible for telephoning reports of suspected child abuse or neglect and filing additional report(s) with appropriate agencies.
   1. The telephone report will include the following:
      a. Name, title, and daytime number of reporting party, agency name and address, and date of report.
      b. Name, address, age, and present location of minor.
      c. Any information that led the reporting party to suspect that abuse has occurred.
      d. Nature and extent of the minor's injury and condition, if known.
      e. The date and time of incident.
      f. Names and addresses of parents or legal guardians.
      g. Any other information requested by the child protective agency.

Riverside	**San Bernardino**
Child Abuse:	Child Abuse:
Department of Public Social Services	Department of Public Social Services
Child Services Division	Children and Family Services
(800) 442-4918 (24 hours)	(800) 827-8724 (24 hours)

Other Related Responsibilities

A. IEHP and its IPAs are responsible for educating their contracted PCPs of the procedures for reporting abuse or neglect cases.

[3] CA Penal Code, § 11166

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

INLAND EMPIRE HEALTH PLAN		
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10. MEDICAL CARE STANDARDS

O. Mandatory Domestic Violence Reporting

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal 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 Utilization Management (UM) personnel are in a position 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/

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.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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10. MEDICAL CARE STANDARDS

P. Total Fracture Care

APPLIES TO:

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

POLICY:

A. IEHP ensures that Members in need of fracture care by an Orthopedist, as determined by an Emergency Department (ED) Physician, Urgent Care Physician or Primary Care Provider (PCP), receive timely access to care.

PROCEDURES:

A. IEHP allows Members to be seen by these participating Orthopedists for global fracture care without a prior authorization:
   1. Arrowhead Orthopaedics – https://www.arrowheadortho.com/
   2. Newport Care Medical Group – (951) 363-5064

B. When an ED or Urgent Care Physician encounters an IEHP Member with an acute fracture, the ED or Urgent Care Physician shall determine whether the fracture is best treated by an Orthopedist or the Member's PCP.
   1. If the ED or Urgent Care Physician determines it is an orthopedic level injury, the ED or Urgent Care Physician shall choose from the following options:
      a. If immediate care is deemed necessary, refer directly to the Trauma/Ortho Panel doctor on call at the facility; or
      b. Refer directly to an Orthopedist participating in this program at the time of the visit. This would best be achieved by calling the respective Orthopedist office and making an appointment, or by giving the patient a prescription or referral form with the Orthopedist's contact information.
   2. If the ED or Urgent Care Physician determines that the patient may be best treated by their PCP, the ED or Urgent Care Physician shall refer the patient to their PCP immediately, with recommendation to refer the Member to an Orthopedist participating in this program as expeditiously as the Member's condition requires.

C. Participating Orthopedists shall schedule IEHP Members referred for acute fracture care as expeditiously as the Member's condition requires. The participating Orthopedist will not require an authorization from the Member's IPA prior to scheduling the appointment.

D. The participating Orthopedist shall treat the patient and subsequently request authorization from the IPA to ensure claims are processed accordingly. The IPA shall authorize the treatment and payment for global fracture care, including payment for all supplies related to this care.

E. The participating Orthopedist shall communicate the diagnosis and care plan to the PCP.

F. IEHP's Contracts Department reviews the list of participating Orthopedists and verifies their continued participation on an annual basis. IPAs, Hospitals and Urgent Care facilities are provided an updated list of participating Orthopedists. This list is also found under "Special Programs" of the "Providers" portal of the IEHP website at www.iehp.org.

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10. MEDICAL CARE STANDARDS

P. Total Fracture Care

10. Medical Care Standards

Q. Maternal Mental Health Program

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal 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, refer to the following website at: https://www.postpartum.net/professionals/screening/.

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

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

   2. 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 (See Attachment, "IEHP Care Management Referral Form found on the IEHP website[3]).

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

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

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

Program Enrollment

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

B. Members are offered care coordination, care management and initial psychoeducation, which may include but is not limited to the following topics: importance of immunizations, post-partum appointments, and 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 12K1, "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 members to community resources and county agency services. IEHP provides continued outreach and support as needed.

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10. MEDICAL CARE STANDARDS

R. Personal Care Services and Home Health Care Services

APPLIES TO:

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

POLICY:

A. As of January 1, 2023, all IEHP network Providers must comply with electronic visit verification (EVV) requirements when rendering Personal Care Services (PCS) and Home Health Care Services (HHCS) delivered in a Member's home, including visits that begin in the community and end in the home (or vice versa). This includes PCS and HHCS delivered as part of Community-Based Adult Services (CBAS), Community Supports (personal care and home maker services, respite services, day habilitation programs),[1] and all other covered HHCS programs.[2]

PURPOSE:

A. To aid in reducing fraud, waste and abuse by outlining the requirements for verifying in-home PCS and HHCS visits.

DEFINITION:

A. Personal Care Services – Consists of services supporting individuals with their activities of daily living, such as movement, bathing, dressing, toileting, and personal hygiene. Such services can also offer support for instrumental activities of daily living, such as meal preparation, money management, shopping, and telephone use.[3]

B. Sandata Technologies, LLC – State-sponsored EVV system that includes the ability to capture data elements during the visit, data portals that allow Providers to view and report on visit activity, and an aggregator to support oversight and analytics.[4]

PROCEDURES:

A. The following services are not subject to EVV requirements:[5]

   1. HHCS or PCS that do not require an in-home visit;

   2. HHCS or PCS provided in congregate residential settings where 24-hour service is available;

[1] EVV requirements for Community Supports (personal care and home maker services, respite services, and day habilitation programs) go into effect on July 1, 2023.
[2] Department of Health Care Services (DHCS) All Plan Letter (APL) 22-014, "Electronic Visit Verification Implementation Requirements"
[3] Ibid.
[4] Ibid.
[5] Ibid.

3. HHCS or PCS rendered by an individual living in the Member's residence;
4. Any services rendered through the Program of All-Inclusive Care for the Elderly;
5. HHCS or PCS that are provided to inpatients or residents of a hospital, nursing facility including skilled nursing facility or residence of nursing facility, intermediate care facility for individuals with intellectual disabilities, or an institution for mental diseases; and
6. Durable medical equipment (DME).

B. IEHP, its IPAs and network Providers may use Sandata EVV system at no cost. This system captures the following six mandatory data components:[6]

1. The type of service performed;
2. The individual receiving the service;
3. The date of the service;
4. The location of service delivery;
5. The individual providing the service; and
6. The time the service begins and ends.

C. IEHP network Providers that render applicable PCS and HHCS must self-register to gain access to Sandata,[7] and be trained on how to operate the system, and gain access to the EVV Aggregator. Once registered, network Providers will gain access to extensive training and technical assistance, including self-guided learning modules and EVV system demonstrations.[8] IEHP network Providers must be prepared to submit their registration confirmation upon request by the Plan or their IPA.

D. Sandata has the ability to receive data from Providers that choose to use their existing EVV system. Alternate EVV systems must comply with all business requirements and technical specifications, including the ability to capture and transmit the required data elements to Sandata's EVV Aggregator.[9]

E. As a Knox-Keene licensed managed care plan, IEHP may choose to contract with a different EVV vendor. In such event, IEHP must file the resulting administrative service agreement with the Department of Managed Health Care.[10]

Billing and Claims

A. All claims for PCS and HHCS services must be submitted with allowable Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes as

[6] DHCS APL 22-014
[7] https://vendorregistration.calevv.com
[8] DHCS APL 22-014
[9] Ibid.
[10] Ibid.

outlined in the Medi-Cal Provider Manual (see link below).[11] IEHP, its IPA and Providers must also indicate the proper Place of Service or Revenue Code on claims and/or encounters to indicate the rendering of PCS or HHCS in a Member's home.[12]

Monitoring and Oversight

A. IEHP will monitor its IPAs and network Providers to ensure compliance with EVV requirements in accordance with the established guidelines below:[13]

1. Monitor Providers for compliance with the EVV requirements and CalEVV Information Notice(s), and alert DHCS to any compliance issues;
2. Supply Providers with technical assistance and training on EVV compliance;
3. Require Providers to comply with an approved corrective action plan; and
4. Deny payment if the Provider is not complying with EVV requirements and arrange for Members to receive services from a Provider who does comply.

B. When a network Provider is identified as non-compliant with these requirements, the Plan and its IPAs must not authorize the network Provider to perform services and/or withhold the payment.[14]

1. If a network Provider is the employee of a subcontractor, the specific network Provider will not be able to provide Medi-Cal PCS and HHCS services.
2. IEHP and its IPAs shall arrange for Members to receive services from a Provider who does comply.

C. IEHP will utilize Sandata's aggregator to support its oversight and analytics activities.

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[11] https://www.dhcs.ca.gov/provgovpart/Pages/EVV.aspx
[12] DHCS APL 22-014
[13] Ibid.
[14] Ibid.

10. MEDICAL CARE STANDARDS

S. Community Health Worker Services

APPLIES TO:

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

POLICY:

A. IEHP covers Community Health Worker (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 recommends CHW services within their scope of practice under state law. Other licensed

[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.

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

10. MEDICAL CARE STANDARDS

T. Doula Services

APPLIES TO:

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

POLICY:

A. IEHP provides doula services as preventive services and on an initial recommendation, which can be provided through the following methods:[1]
   1. Written recommendation in Member's record;
   2. Standing recommendation for doula services issued by IEHP, physician group or other group by a licensed Provider;
      a. The standing recommendation issued by the Department of Health Care Services (DHCS) on November 1, 2023, fulfills this requirement and remains in full effect until rescinded or modified by DHCS.[2]
   3. Standard form, such as the DHCS Medi-Cal Doula Services Recommendation, signed by a physician or other licensed practitioner that a Member can provide to the doula.[3]

PURPOSE:

A. To prevent perinatal complications and improve health outcomes for birthing parents and infants.[4]

DEFINITION:

A. Doula – Birth workers who provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion. Doulas are not licensed and do not require supervision.[5]

B. Enrolled doula - A doula enrolled either through DHCS or through IEHP.[6]

PROCEDURES:

Covered Services

A. Doula services, which are considered preventive services, do not require prior authorization. These services are provided for prenatal, perinatal, and postpartum Members, virtually or in-

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024 Supersedes APL 22-031, "Doula Services"
[2] https://www.dhcs.ca.gov/services/medi-cal/Documents/Medi-Cal-Doula-Standing-Recommendation.pdf
[3] https://www.dhcs.ca.gov/provgovpart/Documents/DoulaREC.pdf
[4] Ibid.
[5] Ibid.
[6] Ibid.

person with locations in any setting including, but not limited to, homes, office visits, hospitals, or alternative birth centers.[7]

1. An initial recommendation for doula services authorizes the following services:
   a. One (1) initial visit;
   b. Up to eight (8) additional visits that can be provided in any combination of prenatal and postpartum visits;
   c. Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion, or miscarriage; and
   d. Up to two (2) extended three-hour postpartum visits after the end of a pregnancy.
2. All visits are limited to one (1) per day, per Member. Only one (1) doula can bill for a visit provided to the same Member on the same day, excluding labor and delivery. One (1) prenatal visit or one (1) postpartum visit can be provided on the same day as labor and delivery, stillbirth, abortion, or miscarriage support. The prenatal visit or postpartum visit billed on the same calendar day as birth can be billed by a different doula.
3. The extended three-hour postpartum visits provided after the end of pregnancy do not require the Member to meet additional criteria or receive a separate recommendation. The extended postpartum visits are billed in 15-minute increments, up to three (3) hours, up to two (2) visits per pregnancy per individual provided on separate days.

For more information on covered services, please see the DHCS Medi-Cal Provider Manual.[8]

B. If a Member requests or requires pregnancy-related services that are included in the benefits offered through IEHP, then the doula should work with the Member's Primary Care Provider (if known) or work with IEHP to refer the Member to a Network Provider who is able to render the service. Services include but are not limited to:[9]
   1. Behavioral health services;
   2. Belly binding after cesarean section by clinical personnel;
   3. Clinical case coordination;
   4. Health care services related to pregnancy, birth, and the postpartum period;
   5. Childbirth education group classes;
   6. Comprehensive health education including orientation, assessment, and planning (Comprehensive Perinatal Services Program services);
   7. Hypnotherapy (non-specialty mental health service);

[7] DHCS APL 23-024
[8] https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/doula.pdf
[9] DHCS APL 23-024

8. Lactation consulting, group classes, and supplies;
9. Nutrition services (assessment, counseling, and development of care plan);
10. Transportation; and
11. Medically appropriate Community Supports services.

C. A doula is not prohibited from providing assistive or supportive services in the home during a prenatal or postpartum visit (i.e., a doula may help the postpartum person fold laundry while providing emotional support and offering advice on infant care). The visit must be face-to-face, and the assistive or supportive service must be incidental to doula services provided during the prenatal or postpartum visit. The Member cannot be billed for the assistive or supportive service.[10]

Member Eligibility Criteria

A. To be eligible for doula services and be covered under Medi-Cal, a Member must be enrolled with IEHP and have a written recommendation for doula services from a physician or other licensed practitioner of the healing arts, acting within their scope of practice under state law.
   1. The recommending physician or licensed practitioner does not need to be enrolled in Medi-Cal or contracted as a Network Provider with IEHP.

B. Doulas must verify the Member's Medi-Cal eligibility for the month of service through IEHP's secure Provider portal at www.iehp.org. See Policy 4A, "Eligibility Verification" for more information.

C. A Member would meet the criteria for a recommendation for doula services if they are pregnant, or were pregnant within the past year, and would either benefit from doula services or they request doula services. Doula services can only be provided during pregnancy; labor and delivery, including stillbirth; miscarriage; abortion; and within one year of the end of a Member's pregnancy.[11]

Non-Covered Services

A. Doula services do not include diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure. The following services are not covered under Medi-Cal or as doula services:[12]
   1. Belly binding (traditional/ceremonial);
   2. Birthing ceremonies (i.e., sealing, closing the bones, etc.);
   3. Group classes on babywearing;
   4. Massage (maternal or infant);

[10] DHCS APL 23-024
[11] Ibid.
[12] Ibid.

5. Photography;
6. Placenta encapsulation;
7. Shopping;
8. Vaginal steams; and
9. Yoga

B. Doulas are not prohibited from teaching classes that are available at no cost to Members to whom they are providing doula services.[13]

Documentation Requirements

A. A second recommendation is required for nine (9) or fewer additional visits during the postpartum period. A recommendation for additional visits during the postpartum period cannot be established by standing order. The recommending Provider can submit a request for authorization through IEHP secure Provider portal at www.iehp.org or via fax at (909) 890-5751.

B. Doulas must document services provided as follows:[14]

1. Document the dates, time, and duration of services provided to Members;
2. Document information on the service provided and the length of time spent with the Member that visit (for example, documentation might state, "Discussed childbirth education with the Member and discussed and developed a birth plan for one hour");
3. Integrate documentation into the Member's medical record and make this available for encounter data reporting;
4. Include the doula's National Provider Identifier (NPI) number in the documentation; and
5. Ensure documentation and doula service recommendation are made available to IEHP or DHCS, upon request.

Doula Provider Requirements and Qualifications

A. Network Providers, including those who will operate as Providers of doula services, are required to enroll as Medi-Cal Providers if there is a state-level enrollment pathway for them to do so.[15] See Policy 5C, "Provider Screening and Enrollment Requirements" for more information.

B. All doulas must be at least 18 years old, possess an adult/infant Cardiopulmonary Resuscitation (i.e., CPR) certification from the American Red Cross or American Heart Association, and attest that they have completed basic Health Insurance Portability and Accountability Act (HIPAA) training. Additionally, a doula must qualify by meeting either

[13] DHCS APL 23-024
[14] Ibid.
[15] DHCS APL 22-013, "Provider Credentialing/Re-Credentialing and Screening/Enrollment"

the training or experience pathway, as described below:[16]

1. Training Pathway
   a. Certificate of completion for a minimum of 16 hours of training in the following areas:
      - Lactation support;
      - Childbirth education;
      - Foundations on anatomy of pregnancy and childbirth;
      - Nonmedical comfort measures, prenatal support, and labor support techniques;
      - Developing a community resource list; **and**
   b. Attest that they have provided support at a minimum of three births.
2. Experience Pathway - Must meet all of the following:
   a. Attest that they have provided services in the capacity of doula either at a paid or volunteer capacity for at least five (5) years that must have occurred within the last seven (7) years; **and**
   b. Three (3) written client testimonial letters, or professional letters of recommendation from any of the following: a physician, licensed behavioral health provider, nurse practitioner, nurse midwife, licensed midwife, enrolled doula, or community-based organization. Letters must be written within the last seven (7) years. One letter must be from either a licensed Provider, a community-based organization, or an enrolled doula.

C. IEHP ensures doulas complete three (3) hours of continuing education in maternal, perinatal, and/or infant care every three (3) years. Doulas must maintain evidence of completed training to be made available to DHCS upon request.[17]

Billing, Claims and Payments

A. IEHP reimburses doulas in accordance with their Network Provider contract. IEHP does not establish unreasonable or arbitrary barriers for accessing doula services.[18]
   1. Claims for doula services must be submitted with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual.[19] Doulas cannot double bill, as applicable, for doula services that are duplicative to services that are reimbursed through other benefits.[20]

[16] DHCS APL 23-024
[17] Ibid.
[18] Ibid.
[19] https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/doula.pdf
[20] DHCS APL 23-024

2. IEHP makes payments in compliance with the clean claims requirements and timeframes outlined in the Plan's contract with DHCS and current guidance.[21] These requirements apply to IEHP, its Delegates and Network Providers. If a Member chooses to see an out-of-network provider for abortion services, the reimbursement rate must not be lower, and is not required to be higher, than the Medi-Cal Fee-For-Service rate, unless the out-of-network provider and IEHP or its Delegate mutually agree to a different reimbursement rate.[22,23] See Policy 20A, "Claims Processing" for more information.

IEHP Responsibilities

A. IEHP provides doulas with all necessary initial and ongoing training and resources regarding relevant services and processes, including any available services through IEHP for prenatal, perinatal, and postpartum Members. This training must be provided initially when doulas are enrolled with the MCPs, as well as on an ongoing basis.[24]

B. IEHP provides technical support in the administration of doula services, ensuring accountability for all service requirements contained in the Plan's contract with DHCS, and subsequently issued associated guidance.[25]

C. IEHP ensures and monitors sufficient Provider networks within its service areas, including doulas. To support network adequacy, IEHP:[26]

   1. Makes contracting available to both individual doulas and doula groups;
   2. Collaborates with its network hospitals and birthing centers to eliminate barriers to doula services when accompanying Members for prenatal visits, labor and delivery support, and postpartum visits regardless of outcome (stillbirth, abortion, miscarriage, live birth);
   3. Coordinates out-of-network access to doula services for Members if an in-network doula Provider is not available; and
   4. If a Member desires to have a doula during labor and delivery, IEHP must work with its in-network Hospitals and birthing centers to allow the doula, in addition to support person(s), to be present.

[21] DHCS APL 23-020, "Requirements for Timely Payment of Claims"
[22] DHCS APL 23-024
[23] DHCS APL 22-022 Supersedes APL 15-020, "Abortion Services"
[24] DHCS APL 23-024
[25] Ibid.
[26] Ibid.

INLAND EMPIRE HEALTH PLAN		
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